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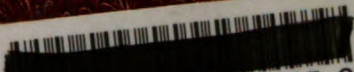
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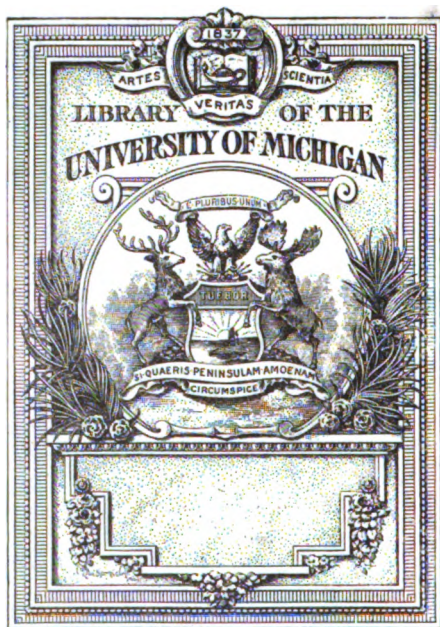
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HOMŒOPATHIC JOURNAL

OF

OBSTETRICS

Gynæcology and Pædology.

PHILIP PORTER, M.D.,

EDITOR.

A. L. CHATTERTON & CO.,

78 Maiden Lane, New York City.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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NO. 1.

JANUARY, 1887.

VOL. IX.

ON THE EARLY RUPTURE OF THE MEMBRANES TO EXPEDITE LABOR.

BY ELIAS C. PRICE, M. D., BALTIMORE, M. D.

Read before the Maryland State Institute of Homœopathy Oct. 21, 1886.

Prof. Sheldon Leavitt has an article in the HOMŒOPATHIC JOURNAL OF OBSTETRICS, for November, 1885, on the "Management of the Fœtal Envelopes during the First Stage of Labor," in which he differs from ten old authors whom he quotes (and he might have extended the list) in regard to waiting "until the os is wide open" before rupturing the membranes.

In the March number for 1886 of the same journal is an article by Professor Edwin M. Hale, on "Early Rupture of the Membranes as a means of Facilitating lingering Labor," in which Doctor Hale quite agreed with Doctor Leavitt in his conclusions, and speaks of a paper which he had prepared and which was read before the Illinois State Society and afterward published in the *Era* and says that Doc-

tor Comstock "cordially subscribes to the same doctrines I advanced, and his influence and practice is certainly worthy of being followed."

Thirty-eight years ago last spring my friend the late Doctor Thomas Daugherty, and late Professor of Physiology in the Baltimore Medical College, remarked to me in conversation a few months after our graduation, "When we have had ten years practical experience, we will care but very little for medical authorities."

Long before the ten years had expired I had learned to think and act for myself in regard to rupturing the membranes. Many a time have I notched the nail of my index finger to convert it into a saw, to cut through the tense and tough membranes that would neither yield to the pressure of the water nor to the pressure of the head.

If the os is only dilated as large as a silver dollar ($1\frac{1}{2}$ inches) and the membranes are drawn straight across it, and do not bulge a particle during a pain, I do not wait very long before rupturing the membranes. As soon as the head is allowed "to impinge upon the inner segment of the os," I am generally rewarded by a rapid dilatation of the os and a comparatively quick delivery.

I have occasionally ruptured the membranes when I thought the labor was retarded by an undue quantity of *liquor amnii*, but not one fourth as often as on account of tough membranes. Some of the old authors say we should wait before rupturing the membranes until the os is dilated three inches in diameter. I think I have ruptured them in a few cases when the os was not dilated larger than a silver half dollar ($1\frac{3}{8}$ inches).

The last case of labor that I attended only a few days ago, the os dilated very slowly, scarcely two drams of water formed in front of the head. About 1:40 P.M. I ruptured the membranes, very little water escaped, dilatation took place much more rapidly; about 6 P.M. we thought best to deliver with forceps on account of deficient pains.

NORMAL LABOR.

BY N. W. VANDENBURG, M.D., FORT EDWARD, N. Y.

The understanding thoroughly what normal labor is, like the acquaintance with the normal functions of the body in health, is a necessary part of the obstetrician's knowledge.

This is excuse enough, or at least should be sufficient, if any were needed, for the present article. I propose to give not a theoretical, but a real case; to neither add to nor take from its history in any way, intentionally.

Mrs. —, age 29, height less than four feet six inches, weight usually about eighty-five to ninety pounds, but just previous to confinement one hundred and eight pounds, was confined of her first child on the 7th of November, 1886. Her health for the last few weeks preceding confinement had been excellent; appetite very good; sleep sound; bowels regular, every day; urine frequent, free from albumen, normal in every respect; digestion usually accompanied with some nausea; salivation constant, as it had been from the end of the first month. This last manifested itself as a constant secretion of saliva in the mouth, calling for spitting every one to three minutes all the waking hours, but not occurring during sleep after the first two months. No pain or soreness was felt in any part of the body, and the abdominal muscles needed no help by way of supporter to carry the increased uterine bulk. The monthly period had been distinctly marked during the whole pregnancy by one or two days of mental depression, uneasiness and increased bodily fatigue.

In one case, at the sixth menstrual period, the interval was only three weeks. All others were four weeks. Labor began at the end of the thirty-ninth week, owing, as it seems to me, to the menstrual effort showing itself at the end of three weeks instead of four at the sixth menstrual cycle.

Knowing the period of the first menstrual effort after pregnancy begins, and a woman's feelings will generally

show this, we may calculate with pretty fair certainty *the day* of confinement. This will be thirty-five or thirty-six weeks farther on. Anything that tends to hasten the menses will hasten confinement. This is a pretty safe rule.

The pregnant woman is, however, more sensitive to influences than the unimpregnated; hence what might only slightly tend to bring on the menses, becomes dangerous during pregnancy.

Labor began about 6:30 A. M. For two days previous there had been warning, in the way of several pieces of clear, thick, tenacious mucus, as large as a bean. These were doubtless cervical, and when well marked may be pretty safely set down as diagnostic of impending labor. No pain or discomfort of any sort whatever was experienced on the preceding day, nor during the following night. Late in the afternoon a drive of two or three miles was taken, going at a good smart pace in an easy-riding top buggy. A hearty supper, followed by a good night's sleep, was an excellent adjuvant to the supreme effort.

Pains, at first of a paroxysmal character, occurred about half an hour apart, waking the patient out of sound slumber. Being a good sleeper, entirely free from nervousness and apprehension, she succeeded in gaining ten or fifteen minutes' sleep between each pain. The pains now were felt over the umbilical region, from side to side, like colic pains, but slower in beginning and ceasing. As time passed on the pains grew more frequent, until by 8 A. M. they were occurring as often as every five minutes.

It should have been mentioned that on the advent of the first severe pains, at about 7:30 A. M., examination showed the head presenting in the left anterior occipital position, and the pelvis free from obstruction. An omission to examine a case of labor at the very first opportunity is a grave error, and one that ought never to occur. At about 8:30 a hearty breakfast of meat, potato, coffee and cakes was taken, during the intervals of pain. This was rejected

about an hour later in a stage of normal digestion, probably a reflex effect of the very severe pains. From the time breakfast was taken to 10:30 A. M. the bowels moved several times, a little at a time, always voluntarily. Most of the time was spent in bed, but occasionally a little walk was taken about the room. Only one person beside the doctor was present. This is much preferable, unless the mother desires others. Nothing more aggravating to an intelligent mother can be invented, than three or four useless persons standing or sitting around, bustling, gossiping, making themselves comfortable generally, and the patient and the doctor uncomfortable in particular. The husband or the mother of the patient are all I want about at such a time. The average nurse is an intolerable nuisance. But *de gustibus non disputandum*. At about 10:30 the pains having become very severe, more being felt in the back or hips, however, probably from the good size of the pelvis, but with severe cutting all over the abdomen, and especially low down in the hypogastrium, the use of chloroform was begun. The corner of a soft towel was saturated with a teaspoonful or so, rolled firmly up to a convenient size to grasp with one hand, while the other was used to stretch the perineum. Two fingers at first, later on three, all well oiled, were introduced with the palm toward the spine of the mother, and at each pain firm, even, steady pressure was made down and backward on the border of the perineum. At the beginning of each pain one good full breath was taken from the chloroformed towel, care being taken to hold it one and a half or two inches from the face of the patient, so as to get plenty of air mixed with the vapor. This breath was held and the patient assisted the expulsive effort with the voluntary muscles. Great relief was experienced from the first inhalation; and farther on, when the pains became of longer duration, two or even three breaths were taken. During one of these pains, at about 10:45, the membranes were ruptured, the first gush of water being

caught in a small basin crowded against the buttocks. The mother was allowed to lie on her back or on either side, as she chose, and at different times assumed each of these positions. As the head descended into the pelvis, it passed rapidly downward, soon resting upon the sacro-ischiatic ligament. This has always been, in my experience, a pinching place. Once by this, the perineum soon becomes fully distended.

In the present case, the head descended three several times against the perineum, and after resting there during the continuance of the pain, receded partially into the pelvis. The mother was told to restrain voluntary expulsive effort as much as possible, in order that the perineum might have time to distend and relax. Just previous to the first descent, and while the perineum was partially distended, a small sponge the size of a thimble, saturated with a six or eight per cent. solution of cocaine, was passed over all the inner borders of the vulva; and within next the presenting head as much as possible. The mother afterward declared that numbness set in almost immediately, and continued during the rest of labor. As the head receded the third time, it, together with the inside of the vulva, was plentifully anointed with fresh, sweet lard. Then came one more pain; the mother was told to use her whole force steadily and tenaciously to expel the child; the head slowly emerged, the encircling vulvar band being gently and firmly crowded down with the palmar surface of thumb and fingers encircling the head, the palm against the posterior commissure, and as the face slid over the posterior border, the doctor's forefinger ran hastily around the neck, but found no encircling umbilical cord; the head firmly grasped beneath chin and occiput by the two palms, was allowed to *rotate freely* as it would under gentle traction; in four or five seconds more the face turned toward the mother's left leg, the body passed easily into the world, and the infant gave its first cry—the blessed sound that makes motherhood

complete. The mucus was wiped from the infant's mouth and eyes, she was turned upon her side, and encouraged to cry by gently slapping the face with the soft corner of a towel. Gentle blowing in the face also was used, to make her catch for breath and fill the lungs completely. Unless great and immediate necessity of the mother, like syncope, sudden flooding, or some such dire necessity immediately supervenes on the delivery of the child, nothing should distract the doctor's attention until the infant has fully and freely expanded the lungs, by vigorous cries and repeated full inspirations.

When these were established, a warmed flannel was covered over the little one, its nose, eyes and mouth again carefully cleansed, and then it was allowed to lie quietly for full five minutes.

I do not see the use of waiting for the pulsations in the cord to entirely cease. There can be little, if any, return circulation from the placental veins, and it seems to me more of a theory than a proven fact that it is beneficial to the infant. How it helps or hinders the closing of the foramen between the right and left heart, I am unable to see, as proven either way. The main occasion for letting the child lie quietly for a few minutes, has always seemed to me most reasonable, as not increasing the severity of the shock that comes with the sudden change from uterine, watery, warm, soft surroundings to rough, cold, respiratory life. When the circulation and respiration are fairly established, the cord may safely be ligated, pulsations or no pulsations. It is often necessary to cut it before, in abnormal deliveries, as when the child is livid or black, feeble and without motion or respiration; but these are not the topics in hand. The cord was ligated at a point from an inch and a quarter to an inch and three-quarters from the umbilical skin. Soft, ordinary wrapping twine; doubled and *not* twisted, the first knot *twice* looped (surgeon's knot), and drawn down firmly, held for a few seconds, the second single

and very firmly drawn. About an inch farther toward the mother, a second knot was tied; the ends of the twine cut to an inch long, the cord severed between the two ligations, the little miss wrapped in the flannel about her, and laid into a well-heated flannel blanket and carried near the stove, placed on the attendant's lap, *feet* toward the stove, head warmly covered, *nose* in sure communication with the external air. Now was time to turn attention to the mother. Gently and firmly grasping the uterus with one hand, two fingers of the other having been passed up the vagina with all possible caution and tenderness, the presenting placenta is received between them, the tips if possible, touching the cervix. Now by gently and firmly grasping and kneading the uterus, the placenta is forced down and the fingers in the vagina are on the lookout for several things. First, to see that the placenta advances; second, to see that the cervical fibers join in the contraction of the uterus; third, to see that they do not contract too forcibly and cut off the exit of the membranes. In about one minute the vagina was filled with the placenta, the cervix had retreated beyond reach, the uterus had resumed its three-cornered, flattened, tapering, polyhedral shape, and at the end of a couple of minutes more a basin was placed near the body of the mother, not against it, traction slowly and firmly made on the cord, the mother told to "bear down," and the placenta expelled and received into the basin.

The firmly contracting uterus had grasped some of the thinner membranes and held them tenaciously. Very gentle traction was now employed, haste made slowly. Soon the grasp slackened, the membranes slowly yielding without tearing and the whole safely out of the way in not far from five minutes from the first manipulation. A soft cloth the size of a small towel was wrung out of very warm water, one part of it left dripping wet, and this laid gently against the sore maternal parts. Nothing can be more grateful at this time than this warm, moist cloth. It was now half-

past eleven A. M., just about six hours from the beginning of labor. The infant, a six pound, strong girl was quietly snuffling by the fire, the mother free from all the parts of the ovum, and ready to be made comfortable. A folded sheet had been placed beneath her over the sheet on the bed, and beneath that an ample soft oilcloth protected everything. A clean night-dress was brought from near the fire, the short one worn during labor removed, the soft undervest that had been kept tucked up out of the way left on, a clean, warm sheet rolled lengthwise was partially spread on the opposite side of the bed, the one underneath on the bed being pushed close to the mother, and the roll with it, the upper sheet prepared in the same way had replaced the upper sheet on the bed, by sliding along beneath the covering, and the patient was now gently and slowly lifted first shoulders then feet over into a clean place, on a folded warmed sheet. To slide off in a heap the soiled bedding was only the work of a moment, and now in a clean bed, comfortably and decently spread, the mother was in a state to rest. At half-past twelve she nursed the washed infant; at half-past one she had a dinner of broiled beef steak, coffee, bread, baked potatoes and rice pudding, and ate heartily. For supper she had an egg beaten in a glass of milk, a cup of weak tea, a couple of slices of toast, some baked sweet potato. Every meal after this was equally hearty. She made a rapid recovery; slept well the first night and every night. Had not an hour's headache, not half a degree of fever, not an hour's trouble with the glands of the breast.

After pains, moderately severe, came on whenever she moved, or the child nursed, for the next twenty-four hours, but only then. The flow was about a napkin in two hours for the first six hours, then one in three or four for the next twenty-four; then one in six. A slight niche in the internal labium of the right side about a quarter of an inch from the posterior commissure was found to have occurred, but it did not extend to the external parts and was not more than a

quarter of an inch deep. The nipples were quite sore on the ends for the first three days, but they were carefully washed after each time nursing, and anointed with a little glycerine and tannin, a teaspoonful of tannic acid to an ounce of glycerine. By the fourth day this was discontinued, and now at the end of five weeks she says she "would not know she had borne a baby, if she did not see it around."

In my next I will give a normal infant for the first two months.

A CASE FROM PRACTICE AND QUESTIONS RELATING TO GYNÆCOLOGICAL SURGERY.

BY L. A. PHILLIPS, M. D., BOSTON.

About three years ago Miss B——, a maiden lady then 38 years of age, complained of suffering much pain in the pelvis, and of having excessive and protracted hæmorrhage at her monthly periods. Examination revealed quite a large interstitial fibroid in the anterior wall of the uterus, apparently about $3\frac{1}{2}$ or 4 inches in diameter. Iodide of lime was given as an internal remedy, and local applications of bell. and glycerine were made two or three times each month for five or six months, after which the pain and flow had become so much less that she neglected treatment much of the time, but came in occasionally during the following two years, and as a result not only was the pain and hæmorrhage almost entirely controlled, but the growth seemed to be diminishing somewhat in size, and also to be working down more and more toward the cervix.

Last spring she reported an increasing pressure upon the bladder, causing much discomfort in standing and walking, and I found the tumor had settled down so as to be mostly in the anterior wall of the cervix. By small tampons of wool, this pressure was somewhat relieved, but it was a con

stant source of discomfort which rather increased from month to month. I therefore advised her to have it removed, inasmuch as it was now in a position where there was little danger from an operation, and no great difficulty in reaching it. Accordingly on Oct. 4th she came to my private hospital and with the assistance of Drs. Kent, Hadley and Percy, I extracted the tumor, which was about the size of a turkey's egg, and as you may see, purely fibrous in character. By cutting away a V-shaped section of the thin attenuated anterior wall of the cervix and stitching the edges together as in the operation for a laceration—it was left in a perfectly normal condition and shape, except for a little elongation. The loss of blood was very slight, not more I should think than half a teacupful.

The operation was made under a constant stream of warm water which was supplied from a tank through a tube on the same plan as that of the fountain syringe.

This I do not claim as anything new or original, but I wish to call your attention to it as a much neater and more convenient means of cleansing a wound than by sponging. Not only is the blood more perfectly washed away, but there is no obstruction to continuous work by the surgeon. By a proper arrangement of the rubber cloth under the patient all the water can be made to flow into a large basin or tub at the foot of the operating table, and all bother of washing sponges and changing and emptying basins and buckets is avoided. This method of cleansing is of course applicable to all operations upon the genital tract, and is worthy your trial if you have not already tried it.

It may be asked, Why did you not continue the internal treatment? or why resort to an operation? or why did not the iodide of lime effect a complete cure?—and these are questions that I am ready to discuss.

As to the treatment by this remedy, it must be admitted that much good was accomplished, as the pain and hæmorrhage were almost entirely controlled and the growth instead

of increasing, diminished in size—and had its location been such as to involve an operation in any great danger, or to have caused no great inconvenience by mechanical pressure, I should not have considered an operation necessary or advisable. But when it became apparent that with safety and certainty we could end the trouble in a short time by surgical means, it seemed to me not only justifiable, but the *only* proper course to pursue. To allow a ball or a sliver to work out by a long process of suppuration, when it could be easily reached and extracted, would be no less rational than to leave untouched a tumor like this. And this principle should it seems to me be applied to all our cases, *i. e.*, if by an operation which does not seriously endanger life, we could remove or cure a difficulty which by other means would be only palliated, or would require a long time and much discomfort to cure, we are doing an injustice to our patients, and bringing reproach upon our profession, if we ignore or neglect to apply the more direct and sure remedy.

Let us follow this question still further—What can be the possible reasons for ignoring all operative measures? We know there are some who conscientiously disapprove of all mechanical or surgical procedure, especially as applied to women's diseases, and no evidence or argument can cause them to think otherwise: but this is no *excuse*, as it is as irrational and absurd, in the light of present knowledge and experience, as to conscientiously disbelieve that the earth is a sphere, because it does not appear so from our individual standpoint. If this ground is taken because one does not feel disposed or prepared to do surgical work, there is still no valid excuse for not having it done. He may not so intend it, but in keeping patients under treatment, and in a more or less diseased condition, when operation alone can *cure*, a physician is wronging them, and laying himself open at least to the suspicion that he either does not recognize

the true condition and the proper means of cure, or he is acting from mercenary and unworthy motives.

Again there are those who discountenance and even condemn any procedure which is an innovation upon the old established course of our fathers or our text-books. But we can all remember when ovariectomy was almost universally considered a reckless and unwarrantable operation—one which no surgeon in good standing was willing to undertake or even countenance. What is the present feeling, however? We know that no one operation has given new lease of life to so many suffering women as ovariectomy, and that *now*, instead of being looked upon as unjustifiable and reckless, the physician who fails to recognize and advise it when a patient is known to have an ovarian tumor is justly condemned as ignorant, incompetent, or at the very least woefully behind the times.—We should learn from this and other similar instances, to hold ourselves ready to recognize a possible merit and value in measures which we may not have applied, and which we may even question, but which we have no right to *condemn* without thorough investigation and trial.

And now I want to raise the general question of operative gynæcology.

In the light of present knowledge and experience, not of any one individual but of the medical profession as a whole, can there be found any justification or excuse for limiting our treatment of women's diseases to medication and simple routine mechanical measures: which in many cases must be acknowledged to be merely palliative and temporary in their results?—Assuming that all are informed and convinced of the progress made and the results attained by operative measures in gynæcological practice there can be no question as to their advantage and superiority in many conditions which we are all called upon to treat. Now it remains for us to do one of three things, viz., qualify ourselves to do whatever may be for the best interests of our

patients, whether it be operative or otherwise; or—as this is not practicable for all—we must at least recognize the need, and advise the performance, of operations in the many cases which would be cured thereby, calling to our aid if need be the assistance of a surgeon in whom we have confidence; or third, we must do our patients the injustice and ourselves the discredit of temporizing, palliating, and substituting for the best and proper treatment that which is unquestionably inferior.

For myself I must choose the first of these alternatives; but I do not wish to be misunderstood to imply that others who may not do so are choosing an inferior course. We must all recognize the fact that by nature many are disqualified for surgical work, and many more from force of circumstances cannot fit themselves to do it as they would want it done for their patients, and for these it is much better to delegate to others who can do it the operative treatment necessary, than to do it in an imperfect and unsatisfactory manner. And even regarding those who never see or admit the necessity of any surgical interference, I would not have it inferred that I accuse them of wilfully deceiving and wronging their patients, for I do not think so, but I do think they fail to recognize conditions and needs which exist and *must* come under their observation; and because unrecognized, they are not given the best curative treatment—and I would only insist that such should in justice to themselves as much as to their patients, learn to distinguish and recognize surgical cases and *have* them properly attended by others if they cannot do it themselves.

In conclusion let me say that all these questions are raised, less to express my own views and opinions than to call forth a free expression of opinion regarding them by others. And for this purpose they are respectfully submitted.

[The Editor desires to add that the pages of the journal are open to any one wishing to accept Dr. Phillips' suggestion "for a free expression of opinion regarding" the treatment of the case.]

SEPIA.—A CASE OF CHRONIC RETROVERSION.

BY M. A. BRINKMAN, M. D.,

Prof. Gynæcology in the New York Med. Coll. and Hosp. for Women.

Mrs. L. consulted me in Oct., 1886. Her illness dated from birth of her only child, ten years previous. During the past year her health and strength failed so rapidly that her friends became alarmed. Change of air and scene failed to benefit her, as had also homœopathic treatment ; but in justice to the family physician, the patient stated that she had refused physical examination of the pelvic organs.

For a year she had been suffering from profuse yellowish green leucorrhœa, so profuse as to render the use of a napkin a necessity. The discharge was not excoriating but the odor was *very fœtid*. The menses were regular, but the flow had of late become more scanty and was preceded by intense colic-like pains. She suffered from constant dragging pains in the bowels. Great fatigue from the least exertion, aggravated by walking ; ascending stairs or walking caused shortness of breath. Patient extremely nervous, frequent spells of trembling. Severe pain in the epigastric region about two hours after eating. Skin dry and harsh, with eruption like water blisters appearing mostly upon the arms and in successive crops. The eruption itching and burning in character ; aggravation of symptoms mornings and about 5 P. M.

Examination of the pelvic organs revealed complete retroversion, bi-lateral laceration of the cervix, nearly to the vaginal junction, with considerable thickening of the surrounding cellular tissue.

Treatment (mechanical). The organ was lifted as near to the normal position as could be accomplished under the existing conditions and was supported by a tampon soaked in glycerine. The patient was directed to remove it early on account of the profuse and fœtid leucorrhœa, and (medicinal)

powders of sepia 200 were given, to be taken three hours apart, and the patient was directed to return in two days. On her return she reported that the leucorrhœa had ceased entirely. There was a slight whitish discharge about the cervix, free from odor. The leucorrhœa has not returned. It is worthy of note that this patient could not use vaginal enemas. All such attempts had been followed by severe uterine colic, due, doubtless, to the open condition of the os. The patient has steadily improved, is gaining in flesh and color, and expresses herself as "feeling quite her old self." Sepia and the mechanical uterine support has been the only treatment. The epigastric symptoms were the last to yield, the use of coffee was prohibited and the epigastric pains soon disappeared. Trachelorrhaphy is contra-indicated. In analyzing the symptoms we must inquire how far they were mechanical and what effect sepia had over their removal. Version and prolapse of the uterus keep up the obstruction to the circulation. Traction on the ligaments causes dragging pain in the abdomen; obstruction to the pelvic circulation causes passive congestion, from which may result cervico-uterine catarrh and cellular infiltrations. Passive congestion may cause menorrhagia or scanty menstrual flow.

"Sepia acts through the vegetative nervous system."

"It especially acts upon the vascular and lymphatic system of the genito-urinary tract." "It causes obstruction to the portal system."

"The uterine condition, of which sepia is curative, is one of passive congestion." The characteristic symptoms, "Pressing in the uterus oppressing breathing," "Profuse leucorrhœa having a fœtid smell," "With drawing pains in the abdomen," "Violent colic before the menses," "Moist eruptions," "Cramp-like pain in the stomach," were present in this case.

By repeatedly replacing the uterus and maintaining it temporarily in position by the tampon, the obstructed circula-

tion was relieved, as also the traction upon the ligaments and cellular tissue—[More upon the latter, however.—P.]—and thus the cure was hastened.

This being an ordinary case my object in reporting it is to draw attention to the fact that it had been in under the care of a homœopathic physician in good standing who doubtless could and did recognize sepia symptoms. The question arises could a cure result in so short a time, if at all, while the heavy retroverted uterus remained in the hollow of the sacrum?—[No.—P.].—Reports of cases with results of the action of remedies would be instructive, if a local examination were made first and the pathological conditions noted.

[Dr. Brinkman's report is, indeed, one of the most interesting we have had the pleasure to publish for some time : interesting because it furnishes both food for reflection and of study in gynæcological practice. First, how much influence had the mechanical treatment in the general result, and, second, how far did the sepia 200, go toward re-establishing the lost elasticity of the connective tissue,—the actual support of the uterus. We wish more clinical cases from practice were reported. It is these "every day cases" that we need to dwell upon, and leave the intricate cases to specialists.—EDITOR.]

SEVEN MORE CASES OF OCCIPITO-SACRO-ILIAC POSITION.

BY ELIAS C. PRICE, M.D., BALTIMORE, MD.

Read before the Maryland State Institute of Homœopathy, Oct. 21st, 1886.

In the HOMŒOPATHIC JOURNAL OF OBSTETRICS for May, 1883, page 395, I published ten cases of the above position. The following cases have occurred since :

CASE XI.—April 12th, 1883. Called about bed-time to see Mrs. A. T., aged 21, in labor with her first child, taken with pain about 8 P. M. Finding there was no dilatation of the os and its edges rather hard, I gave a few drops of gels. in half a glass of water, teaspoonful every half hour ;

laid down in an adjoining room and requested to be called if needed ; arose at 5 A. M., found the os in the same condition it was last night, waited until 6 A. M., no change ; gave half grain of sul. morph. to suspend the pains ; instead of suspending them they continued, and in a very short time the os began to dilate. About 10 A. M. dilatation had taken place pretty fully ; believing from an examination of the fontanelles that I had a case of occipito-sacro-iliac position, I administered a mixture of ether two parts and chloroform one part ; on reaching the child's ear I found my diagnosis was correct. The neck of the uterus had now slipped over the head and was so firmly contracted around the child's neck that I could not insert my finger sufficiently far to reach the child's shoulder, so I had to content myself with rotating the head, and applied the forceps at once to prevent the head from changing back to its former position ; at 11 A. M. she was delivered of a female child, weighing, I suppose, about ten pounds.

A few days afterwards the mother had an attack of malarial fever, which lasted three or four days, after that she did very well.

CASE XII.—July 24th, 1883, to see Mrs. G. C. A., primipara, aged 24. Occiput to the left sacro-iliac-synchondrosis. Gave chloroform, rotated and delivered with the forceps. About the fourth day the mother had some cystic inflammation, with that exception, the mother and child did well.

CASE XIII.—Jan. 26th, 1886. Mrs. F. B. H. Second child. Forehead under pubic bone. Gave chloroform ; rotated the head ; the child was born during the third pain after rotation.

CASE XIV.—April 25th, 1886. Mrs. J. F. A. B., primipara. On account of the head filling the hollow of the sacrum, I did not suspect anything unusual. As the labor made no progress, after waiting a reasonable time, I applied the forceps and delivered ; to my surprise, the child came face upwards. A few days afterward the mother had

a severe attack of intermittent fever, was cured in a few days; child did well.

CASE XV.—Aug. 6th, 1886. Mrs. J. E. S. The progress of the labor being slow, and the hollow of the sacrum not being filled by the head; an examination revealed an occipito-sacro-iliac presentation, the forehead to the right acetabulum. Finding it very difficult to get her fully under the influence of chloroform, I proceeded to rotate the body and head; the child was born in half an hour; mother and child did well, except an attack of malaria by the mother, which was relieved in a reasonable time.

CASE XVI.—Aug. 25th, 1886. Mrs. R. S. G., primipara. Finding the forehead to the right acetabulum, after the inhalation of chloroform, I tried to reach the shoulder, but the parts being small and the neck of the uterus firmly contracted around the child's neck, I only partially succeeded in rotating the body, rotated the head, but before I could apply the forceps the head had turned back again. Delivered with face upwards. The perineum was lacerated more than half way back; but she would not submit to any kind of surgical treatment, insisting that her flesh healed so quickly that she did not apprehend any trouble; but it will be necessary to freshen the edges and secure them in apposition at some future time.

CASE XVII.—Called October 17th to see a primipara. The pains did not seem to be genuine, yet they would neither yield to treatment nor produce any effect on the contents of the uterus. For twenty-four hours or more the os remained in the same condition. By 4 P. M., on the 18th, the os being fully dilated, I suspected a mal-position of the head. The patient passed very easily under the influence of chloroform. On examination the forehead was found pointing to the left sacro-iliac-synchondrosis. I found the uterus so firmly contracted that I could not reach the shoulder, the parts also being rather small internally. I therefore contented myself with rotating partially the head,

and held it in position waiting for the return of the pain, which had been entirely suspended by the chloroform. After waiting fifteen or twenty minutes the pains very slowly returned; at first they were very feeble; as the pains brought the head and my hand down I increased the amount of rotation until the head was fixed. The pains continuing to be ineffectual we applied the forceps and delivered her at 6:05 P. M. without difficulty; but the shoulders were very large and delivered with some difficulty. It was found the next morning that there was considerable laceration of the perineum, supposed to have been produced by the passage of the shoulders. Serre fines were inserted and she is now doing well.

CASE XV, although not fully under the influence of chloroform, was entirely unconscious, and had no recollection of any operative interference.

I have had two other cases in which the head came down on the perineum in just the same position in which it passed through the upper strait, spontaneous rotation not having taken place. I rotated in both cases and delivered with the forceps. In one of the cases the antero-posterior diameter seemed shorter than usual, that may have prevented rotation. I have not lost a child in any of the seven (or nine, if you please,) cases reported.

As my first ten cases, in which my mode of diagnosing and treating such cases is given, was written and published nearly three and a half years ago, I will repeat the directions there given for the benefit of those to whose notice the subject may now be brought for the first time.

The first thing that arrests my attention is, viz.: The child's vertex seems to rest *upon* the upper part of the pubic bone; the head *generally* does not pass back into and fill up the hollow of the sacrum; sometimes you can pass the fingers over the occiput and distinctly feel the nape of the neck.

If the head is not very much *compressed* and the bones

very much *overlapped*, you can often make out the position by the situation of the fontanelles.

From my limited experience I would suggest the following rules:

1st. Never attempt any manual interference until you have confirmed your previous diagnosis of the position of the head, by introducing your hand and ascertaining the position of the ear. If the helix points toward the sacrum you know that the forehead is directed toward the pubis.

2d. Never attempt the above examination until the patient is completely anæsthetized.

3d. Always, if possible, rotate the body of the child before attempting to rotate the head.

4th. As the forehead generally points toward either one or the other acetabulum, always rotate in the direction that the face already points.

5th. Push the head up if you find it difficult to make the rotation.

6th. If you think there is a malposition, try to ascertain the fact, and if necessary, rectify it as soon as the os is sufficiently dilated to admit the hand.

I have always operated with the patient lying in the usual position in bed; in some cases of primiparæ it might be advisable to place the patient in the position for using the forceps in the upper strait.

OPERATION.

The patient being unconscious, you lubricate the hand and also the soft parts, close down the thumb and introduce the hand into the vagina, find the ear, and, if your diagnosis is confirmed, push the head gently up, pass the finger tips into the uterus, place them on the front part of shoulder near the end of the clavicle, and rotate the body in the desired direction; then as you withdraw the hand, seize the occiput in your palm and rotate it toward the pubis. If the uterus is not too firmly contracted upon the

body of the child you will have but little difficulty in making the rotation; but if the uterus is very firmly contracted, you will find it otherwise. I sometimes apply the forceps and deliver at once; if I think the pains will be sufficient of themselves I wait.

SOME NEW REMEDIES IN GYNÆCOLOGY.

BY PHILIP PORTER, M. D., DETROIT.

EUPION (tar water).—This remedy was first brought into prominence by the empirical use of the drug, or we might say, a tea to be drank for colds and certain forms of rheumatism by a class of men called "wood burners," who made it by a process peculiar to their own. They collected the "tar like substance" which oozed from the end of a burning stick and poured water over it and allowed to stand for twenty-four hours before using as a drink. It was highly regarded as a remedy for colds and rheumatism, employed of course empirically. The action of the preparation was first brought into prominence by a certain train of symptoms which always manifested themselves when the "water" was too freely indulged in. This peculiarity led to a thorough and systematic proving of the distillation. In recording the symptoms we will confine ourselves to that portion brought out in the lady provers and most interesting to the gynæcologist.

Pathologically speaking the action of eupion is upon the sympathetic nerve system through which the vascular supply is distributed; the effect on the heart is quite striking, producing an intermittent pulse, very irregular at times, pale face and anxiety; followed by a weak and prostrated feeling. The capillary system seems to be its great field of action: the equilibrium being disturbed all through the proving.

During the proving the ladies complained of a severe backache which was relieved by lifting the weight of the body up from off the pelvis: leaning over the foot of the bedstead, permitting the lower extremities to hang or sag down from the hips also relieved the backache. Any position that was assumed which allowed the weight from above the pelvis to be taken off, brought instant relief. The lumbo-sacral pains were as if the bones had been bruised or broken (Bell., Nux v.). The provers were irritable and easily brought to anger; considerable confusion and slow to collect the thoughts. The genital organs—especially the vulva and vagina—were sore and tender and yet had a pleasant tingling sensation. The pudendi was as if bruised but in the evening had some itching which was temporarily relieved by sitting down on something hard or by the pressure of the hand. All of the symptoms of the vulva were worse during the evening or when warm and perspiring. The vagina was hot and burning; relieved by an injection of glycerine and water. No desire for intercourse. The leucorrhœa was limpid, more like water or warm milk. At times copious leucorrhœa that frightened them. A feeling of exhaustion and general lassitude. In all of the lady provers they menstruated *too soon* and *too profuse*. The menstrual discharge was thin, like water.

During menstruation an uncomfortable, despondent feeling with a disposition to weep; constantly excited and a desire to be obstinate. There was weakness of memory and confusion of ideas; that is, when trying to concentrate her thoughts she would drift off into other directions. Oppression of the chest. Desire for a long breath; soreness all through the chest; the pectoral muscles were sore and tender—as if [bruised. There were also some slight attacks of lancinating pain in the lungs. The abdomen was at times bloated; rumbling of gases, with slight colic pains. At times a dull pain all through the bowels, with a sharp darting pain up through the rectum. All through the men-

strual period the provers complained of a headache, heavy and accompanied with chilliness—pain in the forehead—(frontal) throbbing at times.

After menstruation there was a constant and persistent discharge of a yellow and tenacious leucorrhœa, with itching of the vulva and of the skin between the thighs. The leucorrhœa was greatly modified in quantity and character by wearing at night a tampon of cotton with glycerine. The time of aggravation was from 7 to 9 and 10 in the evenings.

ARANEA DIADEMA.—The Diadem Spider, or sometimes named the Papal Cross Spider, from the peculiar marking of stripes on the back—belongs to the domestic order and may be seen or found in old damp barns and stables; also about old ruined buildings. It has an ovoid body and is a dark brown color with a longitudinal line on its back and occasionally yellow-white spots on its body. This spider differs somewhat from the *arana domestica*—the house spider—is more predaceous, exceedingly fierce and of a sanguinary disposition. They prey with avidity upon insects and other small articulated animals, but seldom turn their weapons against the higher animals.

The preparation for medicine is made by placing the live spider in alcohol, five parts, and keep in a well-stoppered bottle, in a cool and dark place for a week, agitating the bottle several times during the day. The tr. is then poured off and strained and is ready for use. We go thus quite definitely into the history and manner of preparing the drug, as we are anxious to have some other practitioner assist science by adding his or her evidence in proving this, we believe, truly important remedy in treating diseases peculiar to women.

The prominent gynæcological indications—if we may be permitted to use the expression—for this drug are *menstruation, too profuse* and *too early* (one week). During menstruation there is melancholy, despondency or the opposite—a hilarious condition—*chorea* and choreic spasms, hystero-

epilepsy, excessive bearing down pains; sensation of weight with burning in the hypogastrium and the uterus; also burning in the vagina; complains of constant fatigue. Hysteria or hystero-epileptic attacks during menstruation, before or just after, should be relieved (if other symptoms correspond) by *arana diadema*. The mental symptoms are quite characteristic—erratic and spiteful. We believe there is a grand future for this drug in therapeutics, especially in ovarian or uterine disorders where there is associated with chorea or great nervous irritability, want of self-control, sleeplessness, depression of spirits, followed by vivacity.

ARNICA MONTANA. As gynæcologists we are compelled to acknowledge the want of appreciation of the intrinsic value of this drug in diseases of the genital organs. While it has long been employed both scientifically (homœopathically) and empirically (allopathically) for other disorders, its special aptitude for relieving certain disorders of the female sexual organs seems to have been entirely over-looked or underrated. We now regard *arnica* with as much favor in prescribing *as any remedy* in the list of uterine therapeutics.

Arnica is suitable in cases where the nervous system, both animal as well as vegetable, is in a state of torpidity, where the vital powers are low, where there is a chronic state of inflammatory action of the pelvic viscera, a venous stasis of the vagina and uterus or chronic hyperæmia of the ovaries. We have employed it with marked success in cases where there was a sensation of numbness or pressure with a feeling of contusion of the bones of the pelvis and the thighs. We have also prescribed it with good effect when the ovarian and subovarian plexus of veins were enlarged—almost a varicose condition as it were.

During the menopause *arnica* should find a place with lach., sang., puls., coc., con., etc. The menstrual symptoms of *arnica* are quite characteristic—profuse, but does not last long—usually too early by three or four days. The

character of the menstrual discharge is a bright red color (bell., caus., cinn., hyos., ham., ipec., lach., etc.) somewhat coagulated. One of the indications for arnica in uterine affections, at all times, is the discharge of bright red blood, usually in small clots, and a sore bruised feeling in the vagina. There is also soreness across the hypogastrium; does not like to have any thing rest on the lower part of the abdomen. Riding over a rough road causes her to complain or produces a flow of *bright red* blood. In any abnormal condition of the uterus or its appendages from a fall or injury of any kind, a kick or blow from a person, calls for the administration of arnica; also when the patient complains of distress and soreness in the uterine and ovarian region when the bowels move, a feeling of pressure in the rectum when standing.

(*To be Continued*).

BUTTON-HOLING THE FEMALE URETHRA.

BY M. H. PARMELEE, M. D., TOLEDO.

In December of '84, Dr. Emmet announced a new procedure whereby he claimed to be able to accomplish many objects never heretofore obtained. Time enough has now elapsed to examine some of these claims by the light of the personal experience of others besides that of the discoverer. To begin correctly, let us admit that prior to Dr. Emmet's investigations and the invention of his "Button-hole Scissors," the female urethra and its diseases were not as well understood as they might have been. Dr. Skene's endoscope, Dr. Reeves Jackson's tapering tubes and the Sims' urethral speculum gave an uncertain amount of knowledge; but they all require peculiar auxiliaries in the way of light and special training which the general practitioner cannot have, and so were limited in their applications to practice.

The invention of this instrument which I hold my in

hand, and which you can examine, was therefore timely, if it fulfills the purposes for which it was designed.

Every woman has an instinctive dread of an "operation," and only the most prolonged and intense suffering or fear of death will generally drive them to consult a surgeon. It is particularly so with the urethra, but if we can promise them sure relief the battle with their emotions will be half won. Let me relate two cases that are to the point.

Mrs. M., aged 50, of French extraction, had suffered for a number of years with almost constant desire to urinate and inability to strain hard enough to seemingly empty her bladder.

She had consulted a number of physicians, and taken a goodly variety of remedies when in '85 I saw her in consultation. Stricture had been the most common diagnosis, and one surgeon had practiced perseveringly gradual dilatation, without affording her any permanent relief.

Under ether I performed the "button-hole operation," going nearly the entire length of the urethra, and discovered just externally to the sphincter vesicæ (3) intensely vascular prominences which I curetted off, leaving the urethra open. Mrs. M. made an excellent recovery. That was more than a year ago, and she has never had the least return of her trouble. Now, these neuromatoid excrescences could have been removed by the sharp curette as well from the unopened urethra, as after the diagnostic operation; but who could have told with the ordinary instruments of their presence and nature?

This woman had been bedridden for a long period, and the faithful priest was administering the extreme unction of his church when I first saw her.

The nervous jactitation which is an invariable accompaniment of any urethral trouble has not entirely gone as yet; but the lady is about her house and on the street, in comfort and at ease.

Mrs. R., aged 46, American, a thin, spare, nervous woman.

at about 25 years of age, suffered with a pelvic abscess which discharged freely. She had recovered a fair amount of general health; but about ten years ago began to experience pain in the urethra when urinating, and of late could not walk much without great irritation in and about the urethral opening. Upon examination I found an everted and prolapsed urethral mucous membrane encircling the orifice. Here was a case where, under the old rule of procedure, we would have drawn this membrane out and snipped it off, leaving it to cicatrize, forming a stricture most likely and in time to again evert with a renewal of the troublesome symptoms. With the "button-hole scissors" and the assistance of Dr. Barlow and a 4 per cent. solution of hydrochlorate of cocaine, I incised the urethra in its middle, drew the hypertrophied membrane through the opening and fastening it to the vaginal mucous membrane, left it there to form a new orifice. This lady also made a good recovery. In her own language, she told me a month ago, "Why, Doctor, I didn't suppose that any one could possibly make water as easily as I do now!"

These two cases are sufficient evidence of the exceeding merit of this operation.

The ease and certainty with which it can be performed is also greatly in its favor.

The merest tyro cannot go astray in its application. Nor thus far have I had any severe or untoward symptoms arise in the treatment afterward; but I shall not think of opening the urethra again without full anæsthesia. Cocaine is not sufficiently benumbing for use in so prolonged and delicate an operation.

From these cases no other inference can be drawn than one decidedly favorable.

At first thought it seems a formidable procedure, but a little experience with it, demonstrates most unmistakably that its intent and results are only kindness to relieve suffering where other measures have failed.

EDITORIAL.

Homœopathy as viewed by a member of the Massachusetts Medical Society (Regular). By Vincent Y. Bowditch, A. B., M. D. This little monograph of Doctor Bowditch's does indeed give a clear and concise review of homœopathy. The author presents facts—yes, actual facts—that are simply incontrovertible and we accord the writer all honor for his manly and dignified manner of handling this—to him—delicate subject, when he states they are not fighting the “principle of homœopathy or maxims,” but they do most strenuously object to a physician prescribing *expedients* or remedies regardless of the law of “similia” and then call it homœopathy, thereby creating a false impression upon the mind of the patient. We think he has just grounds for criticism.

The time is certainly not yet for abandoning the name of our distinctive school, but nevertheless his “views” upon this important question are worthy of serious consideration and reflection. Query : Is homœopathy progressing? Are we, as homœopaths, increasing? What is the difference between a modern allopath and a modern (so-called) homœopathist? Is the success from a business standpoint of a so-called homœopathic physician due to the fact of his being a “homœopathist” or to his individuality?

THE MEDICO-LEGAL RESPONSIBILITY OF THE SURGEON IN BATTEY'S OPERATION.

A case of especial interest and importance to the surgeon was recently tried at the Liverpool Assizes. The case was one in which a lady patient brought suit to recover damages against Doctor Imlach, an operator of some local reputation, who performed laparotomy on a woman for the relief of a hæmatocele, without first obtaining her consent ; and second, he failed to explain the nature or gravity of the operation to her immediate relations ; and third, the operator did not, as was one of the rules of the hospital, call a consultation of the staff before operating. The woman operated upon was forty years of age, and had borne five children, and had enjoyed fair health up to the time of the operation. Three years previous she had experienced severe pain in the pelvic region for which she was treated and relieved.

One year later she suffered another attack and was again treated and again cured. Now, six months later, she reported to the "*hospital for women*," complaining of the same pain, but this time Doctor Imlach, without consultation with the hospital staff, performed the abdominal operation for hæmatocele, removing at the same time both ovaries, and although entirely relieving her of the disease, in a few weeks, he became the subject of a malpractice suit.

In presenting this case, the attorney for the plaintiff stated "that the woman was admitted to the hospital, suffering from what the physicians termed hæmatocele and that the defendant did perform an operation without her personal consent and that the operation was unnecessary for the disease from which she was suffering; that she was not informed of the nature of the operation and that sufficient time had not been taken for observation and the application of medical treatment before having recourse to surgery."

While a court of law is not the place to discuss scientific questions in medicine or surgery, it nevertheless brings prominently to our notice the question of the indiscriminate spaying of women suffering from diseases which are not considered fatal, and yet the operation forever places them beyond the possibility of that grand and noble physiological act of woman's life, fecundity. During the cross-examination of the different witnesses many interesting facts, as well as theories, were advanced by men of prominence in the profession.

"James M. Bennett, M. D., and surgeon, said that he had for over 25 years practiced in Liverpool in connection with diseases of women. He had had his attention called to the operation performed by the defendant, and taking the entries in his note-book—that the plaintiff was suffering from hæmatocele and hæmato-salpinx—he did not see any thing that would call for the operation being performed without first using other means of treatment. Assuming that the patient first consulted Dr. Imlach in the beginning of 1883, and afterward in the same year, then a cessation of pain until December, 1884, consultation on the 8th December, admission into the hospital on the 15th, and the operation on the 18th, there was not sufficient time given for medical treatment before having recourse to such an operation."

Lawson Tait, F. R. C. S., and surgeon to the Birmingham Hospital for Women, stated that intra-peritoneal hæmatocele was very distinct from extra-peritoneal, and was fatal in 95 per cent. of the cases if left long. In the great majority of the cases it was fatal in three hours if not operated upon. From Dr. Imlach's description of the case he should say that the operation was a most proper one. The plaintiff had also described the disease exactly, and was satisfied that she had recurrent intra-peritoneal hæmatocele. Extra-peritoneal hæmatocele was fatal in about five per cent. of cases.

After a most thorough and searching examination of the case it was given to the jury, who returned a verdict for the defendant.

The London *Lancet* editorially touches upon the subject as follows.

"In the evidence of Dr. Grimsdale, which was of a highly scientific character, one fact very important was stated—namely, that in the Liverpool Hospital for Women, 111 women were spayed during the past year, and 44 during the previous year.

"The highest authorities in this country have justly condemned the frequent performance of spaying, and it is well known that such practice is limited to one or two towns in the kingdom. In America the operation has been performed with great frequency, but there pathologists and physicians have begun to question the frequency of disease. That there are certain cases in which the operation is justifiable and called for can not be denied; but the idea that such cases are common is entirely erroneous."

Out of this suit was brought some very interesting correspondence between men of eminence in that country which stamps upon this much discussed question of oöphorectomy the seal of condemnation by those who are high in authority.

TRANSACTIONS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

BUREAU OF OBSTETRICS.

PUERPERAL FEVER: HISTORY AND ETIOLOGY. BY W. J. MARTIN, M.D., PITTSBURGH.—Professor Lusk says that, "in searching through the records of the Health Department of New

York city, he found that, from 1868 to 1875, inclusive, a period of eight years, there were 3,343 deaths from diseases complicating pregnancy, from accidents of child bearing, or from diseases of the puerperal state; or, in other words, one in seventy-five of all the deaths occurring during that period was the result of the performance of what we are in the habit of regarding as a physiological function."

The gentlemen having charge of the preparation of this paper have not selected the subject of puerperal fever with the belief that they would be able to throw any new light upon it, or with the purpose of advancing any new or original ideas as to its nature, treatment or prevention, but from the belief that a disease fraught with such danger to the life of womankind is worthy of our most serious consideration, and from the further fact that many cases of puerperal fever having occurred recently in the practice of physicians of this society, in the western end of the State, we want to have a full and free discussion of the subject in all its bearings.

We propose, after briefly mentioning some of the opinions held by writers of the past on the history and nature of the disease, to summarize, from the writings of the present day, the latest views on the etiology and pathology. The diagnosis and prognosis will be treated of in a clear and terse manner by one of our oldest practitioners and closest observers. The treatment, which we consider the most important part of the paper, we hardly expect to be exhaustive, and we hope that every member present will add his mite to this part of the paper, so that all may be gainers by having had this subject presented.

Very diverse views as to the nature and causes of puerperal fever have been held and taught by medical authors and writers. Some have held that it is nothing more than violent inflammation of the pelvic organs or the peritoneum differing in nowise from what may occur in the non-puerperal state. Others that it is allied to hospital gangrene; and numerous facts have been published which would lead to the belief that the epidemic form of puerperal fever partakes largely of the nature of erysipelas. Thus in Ramsbottom's *Process of Parturition*, page 426, is the following: "Rigby states that in one epidemic of puerperal fever, at the General Lying-in-Hospital, the child of every woman who died of the disease, perished of erysipelas. And I am acquainted with two instances of a like nature that occurred in the practice of one doctor in the same month. Many have remarked the prevalence of erysipelas, as well as malignant typhus, when puerperal fever was epidemic. On these occasions, I have known the women who nursed patients that died of this fever, become the subjects of erysipelas. A striking instance of the analogy between these two disorders, I saw in the autumn of 1841. Erysipelas was very prevalent, a medical

friend of mine had six cases within a few days of each other ; while closely watching these patients, he attended a lady in labor in the vicinity of two of them. Puerperal fever speedily showed itself, and the patient died. Her nurse was seized with erysipelas of the hand, and placed herself under the care of another doctor. One day after having made an incision and dressed the hand, this second doctor was called to a case of midwifery ; the same kind of fever supervened, and this also terminated very rapidly. I was summoned to the case late at night, and when I arrived, she was dead. A third fatal case attended by the same practitioner I also saw, and others that did well."

Sir J. Y. Simpson believed and taught that there was a pathological connection between puerperal fever and erysipelas. The two diseases, he says, had been repeatedly observed to prevail at the same time in the same town, in the same hospital, or even in the same wards. There were various accurately recorded instances showing that when the fingers of medical men were impregnated with the morbid secretions thrown out in erysipelatous inflammation, the inoculation of these matters into the genital canals of parturient women produced puerperal fever in them in the same way as the inoculation of the secretions from patients who had died of puerperal fever itself. The effused morbid matters in the one disease as in the other were capable of producing the same effect when introduced into the vagina of a puerperal patient.

There is apparently incontrovertible evidence that puerperal fever has been propagated by medical men carrying on their fingers matter capable of producing it, from bodies which they were dissecting, and inadvertently inoculating that matter into the mucous membrane of the vagina of patients in labor ; the perineum is often slightly torn ; the vaginal mucous membrane is generally stretched and abraded ; and the whole affords a surface in a condition easily inoculable.

The immediate cause of puerperal fever is generally considered to be the absorption of putrid matters that lodge in the uterus or vagina. The internal surface of the uterus after delivery has been very aptly likened to a stump after an amputation. If students and practitioners with their hands containing some portion of morbid matter can thus produce puerperal fever, no doubt, under similar circumstances, surgeons have inoculated into wounds they have made or dressed, similar matter producing the similar disease of surgical fever. Dr. Simpson says that since bringing the attention of the profession to the communicability of surgical fever, he had heard various facts in regard to it, all of which more and more convinced him that surgeons, like accoucheurs, are occasionally the unhappy media of inoculating their patients with morbid matter producing surgical fever, as obstetricians by the same means pro-

duce in their patients puerperal fever. He had no doubt it would take many years fully to convince surgeons of this fact, but still it was his conviction that they would ultimately both believe and act upon it, and that their doing so would be the means of preventing many of the deaths which now occur after operations particularly in hospital surgical practice. The achievements of modern aseptic and antiseptic surgery have fulfilled this prediction even sooner, perhaps, than Dr. Simpson anticipated.

Dr. Simpson further says that he does not believe that puerperal fever is usually propagated directly from individual to individual, but indirectly through the medium of a third person, and that person generally the medical attendant or nurse. This belief is founded upon the evidence that the disease is, in most instances, distinctly limited to the practice of one or two practitioners only, out of a large number of physicians practicing in a large community. Many examples were recorded, and many more unrecorded were known to the profession, of the disease being thus limited to the practice of a single physician in a town or city. In these cases we could not believe it to be owing to any morbid influence present in the air, or emanating from the locality in which the cases occurred. For if so, it would affect indiscriminately the patients of all practitioners; but it has been often seen to haunt the steps of a single practitioner, and a single practitioner only, in a community. One illustration given by Dr. Simpson is very striking. "In 1840 upwards of four hundred women were delivered by different midwives in connection with the Lying-In Hospital of Manchester. These four hundred women were delivered in different parts of the town at their own homes. Sixteen of them died of puerperal fever; all the others made good recoveries. The production of this could not have arisen from any general epidemic or atmospheric or telluric influence, for the fatal cases occurred in no one particular district, but were scattered through different parts of the town. These four hundred women, or more, were attended, in their confinements, by twelve midwives. Eleven of the midwives had no puerperal fever among their patients. The sixteen fatal cases had occurred in the practice of one only of the twelve midwives. There must have been something, then, connected with that one midwife, in which she differed from the others, inasmuch as all her patients took the disease, whilst the patients of all the others escaped from it. And in medical philosophy we cannot fancy that this something consists of aught else than some form of that morbid principle or virus, to which pathologists give the name of contagion. Further, that the disease is really, in such instances, propagated by the physician or the nurse, carrying to the parturient patient a virus capable of producing the disease, is shown by the fact that, when the disease has broken out in the

practice of one accoucheur, it will spread to the practice of his obstetrical brethren, provided they put themselves in a condition to carry the contagious virus from the patients of the first practitioner. In 1836 or 1837 Mr. Sidney, of this city (Edinburgh), had a rapid succession of five or six fatal cases of puerperal fever in his practice, at a time when the disease was not known to exist in the practice of any other in this locality." Dr. Simpson, who had then no full and proper belief in the contagious propagation of puerperal fever, attended the dissection of two of Dr. Sidney's patients, and freely handled the diseased parts. The next four cases of midwifery which Dr. Simpson attended were all affected with puerperal fever, and it was the first time he had seen it in practice. Dr. Patterson, of Leith, examined the ovaries, etc., from these fatal cases, and the next three cases which he attended in that town were attacked with the disease. It was upon evidence of this kind that British pathologists generally had founded their belief in the contagious communicability of puerperal fever: and it was evidence of this kind which had driven them to adopt those measures of prevention or avoidance, which are so highly necessary in order to arrest the propagation of this fearful malady. The measures adopted proved, beyond all dispute, the great importance of carefully ridding the fingers from all matters in the least degree likely to prove hurtful if inoculated into the vagina of a puerperal patient. And no doubt such matters were always present in the fingers as long as, despite even of common ablutions, they emitted a disagreeable odor, the presence of that odor being a perfect proof of the presence of morbid matter capable of producing the odor. Dr. Simpson had, for many years, used, for the purpose of ridding the fingers of this morbid matter, a solution of the cyanide of potash. He believed that the imbibition of the effluvia from puerperal fever patients by the clothes of the medical attendant, and the subsequent inhalation of such by the parturient female might be a means of infection. He gives the case of a physician who attended the dissection of a puerperal patient, but did not touch the body or any of the parts. The same evening he attended a lady in labor, and she was attacked with the disease. A medical gentleman, after having lost several cases of puerperal fever, got rid of the disease in his practice by changing his clothes, using chloride of lime, etc., but it again returned to him when he happened to deliver a patient immediately after wearing a pair of gloves which he had used during the time of the puerperal epidemic. And Dr. Simpson, with apparent disgust, remarks that, certainly if there was any piece of our dress more apt to retain the contagion than another, it was this useless and superfluous appendage to our attire. He remarks, further, in speaking of causes, that no doubt sporadic cases of puerperal fever

frequently occur traceable to no contagion, or any other cause capable of being averted, some of them owing to morbid actions going on in the constitution of the patient even before delivery.

As predisposing causes we have given all and any cause which will lead to unhealthy action in general ; a depressed, anxious and desponding state of mind, intemperate habits or deficiency of food, and perhaps previous disease existing in the system. During the periods of the epidemic prevalence of this disease we find that the delicate, the forsaken, the unmarried and the unhappy are the most liable to be attacked, as well as the most liable to be destroyed. Of eight unmarried women who became ill of this disease only two survived. It is an old remark of those who have had much experience in lying-in hospitals, that the single women are peculiarly liable to fatal disease after delivery.

With all that has been said as to the contagiousness, infectiousness and communicableness of the disease under consideration, it may seem strange that we have to record that the *non-contagiousness* of puerperal fever is strongly maintained by many able physicians. The most powerful among these is Dr. C. D. Meigs, who writes as follows : " I have practiced midwifery for many years. I have attended some thousands of women in labor, and passed through repeated epidemics of puerperal fever both in town and in hospital. After all this experience, however, I do not, upon careful reflection and self-examination, find the least reason to suppose I have ever conveyed the disease from place to place in any single instance. In the course of my professional life I have made many microscopical examinations of child-bed fever, but did never suspend my ministry as accoucheur on that account. Still, I certainly was never the medium of its transmission." This statement is indeed remarkable, but it is difficult with any conceivable amount of negative testimony of this kind, to disprove the positive affirmative evidence of many other equally intelligent and no less trustworthy observers.

The following words of Spallanzani are very much to the point here : " It is the custom of certain dabblers in philosophy to deny facts, however particularly described, and though related by persons of the highest authority, merely because their own endeavors (in the same direction) fail of success. But they do not reflect that this is acting in direct opposition to the principles of sound logic by which we are taught that a thousand negative facts cannot destroy a single positive fact." Thus the entire sum and substance of Dr. Meigs's testimony is perfectly expressed in this last phrase ; he certainly was not a medium of transmission of such poison, but this amounts to nothing in disproof of others being such mediums.

The statements already given which prove the direct communi-

cation of poison sufficient to cause child-bed fever, comprise but a very small portion of those recorded in medical works; these prove what may be termed common communicability, by means of which the poison may be conveyed from a variety of sources and under a great variety of circumstances. The testimony of Dr. Meigs must be regarded as anomalous, and as furnishing an example of most uncommon incommunicability. But nature is never one sided, we can find in the recorded evidence of medical men some corresponding anomalies on the opposite side, some still more remarkable instances of most uncommon communicability. Thus Dr. Merriman states that he was present at the examination of a case of puerperal fever at 2 P. M. He took care not to touch the body. At nine o'clock the same evening he attended a woman in labor. She was so nearly delivered that he had scarcely any thing to do. The next morning she had rigors and she died in forty-eight hours. Dr. Gooch relates the case of a general practitioner in large midwifery practice who lost so many patients from puerperal fever that he determined to deliver no more for some time, but that his partner should attend in his place. This plan was pursued for one month, during which not a case occurred in their practice. The elder then being sufficiently recovered returned to his practice, but the first patient he attended was attacked by the disease and died. Very similar was the experience of the unfortunate Dr. Rutter, formerly of Philadelphia, as related by Dr. Meigs. This gentleman seemed to be tracked by the cause of the disease, to judge from the numerous attacks of it in his lying-in patients. He was charged with being a carrier of contagion. Worn out with fatigue and wounded in spirit by his cares for the unfortunate victims of an epidemic disease, Dr. Rutter left the city for the purpose of regaining some strength, and to escape from the repetition of such disheartening labors. He spent ten days rusticated at a distance of thirty-five miles from the city, and on his return he caused his head to be closely shaved, took a warm bath, dressed throughout in clothes entirely new, leaving behind him even his pencil and his watch, and went out to attend a lady in labor, who had a favorable parturition, yet was next day assailed by a horrible child-bed fever, of which she died. (*Guernsey's Obstetrics*, pp. 435 and 436.)

We will now, in closing this section of the paper, quote briefly from Lusk's *Science and Art of Midwifery*. Second edition, 1884. This we take to be our latest and best authority. The teachings of this author, so far as relate to the etiology, etc., of puerperal fever we accept and adopt as our own. He says (p. 608): "It has passed beyond the domain of dispute that puerperal fever is an infectious disease, due, as a rule, to the septic inoculation of the wounds which result from the separation of the decidua, and

the passage of the child through the genital canal in the act of parturition." "But instances of puerperal inflammations and febrile conditions are sometimes observed, in which the symptoms of blood poisoning are apparently absent or are present only to a subordinate extent, and as a late feature of the disease. (These cases, observe, are called cases of puerperal inflammations, not puerperal fever. But from such a starting point a fatal epidemic of puerperal fever might spring.) Of this class may be mentioned 1. Cases of catarrhal endometritis due to errors of diet and exposure. Indeed I have frequently, in hospital practice, been able to trace severe cases of cellulitis, pelvic peritonitis and general peritonitis, occurring in the winter season, to the patient getting out of bed dripping with perspiration and clad only in a night-dress, and going thus over a cold, uncarpeted floor to the water closet. 2. Cases of puerperal disorders proceeding from emotional causes, the nervous system furnishing the first impulse to the disturbed action. 3. Cases of excessive vulnerability in non-pregnant women; individuals are sometimes found so susceptible that a parametritis follows a simple application of the tincture of iodine to the cervix. 4. Cases of pelvic peritonitis starting from old intra-peritoneal adhesions. 5. Cases of peritonitis and retro-peritoneal inflammations secondary to ulcerative processes in the cæcum of the descending colon."

An experimental point of practical importance in connection with puerperal septicæmia is the following, viz : If the injection of a septic fluid be made directly into a vessel, toxic effects speedily follow, but are transitory, unless the amount of the fluid be very large, or its virulence exceptional, or the animal very young ; whereas very small amounts injected subcutaneously, by developing rapidly spreading phlegmonous inflammation, resembling malignant erysipelas in man, are capable, after a period of incubation, of producing fatal results ; or they may, if injected into a shut cavity or underneath a fascia, lead to the development of an inflammation of an ichorous character. In other words the eliminating organs suffice under ordinary circumstances to remove from the blood the same amount of septic fluid which would prove fatal if injected into the tissues. This experience leads us to the conclusion, that in the tissues septic poison possesses the capacity of self-multiplication, and that in the local inflammation set up, a reservoir is formed from which poison is continuously poured into the circulation. This capacity for self-multiplication which septic fluids possess, is found to be coincident with the presence of certain organic bodies, termed variously micrococci, microspores, less specifically bacteria. Carefully made experiments serve to show that if a septic fluid be deprived of these organic bodies by boiling or filtration, while it continues capable of producing inflammation

the inflammation is usually of diminished intensity and remains local in character, whereas the microspores retained upon the filter, possess all the virulence of the original fluid. As to the exact manner in which the minute bodies exercise their pernicious influence, whether they operate mechanically, or whether they produce a virus in the process of nutritive activity, or whether, as is probable, both suppositions are correct, must be left for subsequent investigation. But we can see now that the question as to the extent to which erysipelas and puerperal fever are cognate diseases is in a fair way to be solved. Thus we find in surgical fever, in puerperal fever, in diphtheria, and in erysipelas, the presence of a common element which links them together, and which establishes the relationship which has long been recognized as existing between these various processes. Whether the bacteria are identical in the different infectious diseases in which they have been recognized is another question, but whether identical or not they all possess the common property of penetrating the tissues under favorable circumstances, of multiplying and of producing by their migrations, local inflammations and general infection.

In the *American Journal of Obstetrics* Dr. E. Næggerath describes, with chromo-lithographic plates, a certain form of puerperal fever microbe, which he obtained from blood clots, discharged from the uterus of a woman with a protracted child-bed fever. He denominates the parasite as belonging to the saprophytes, and says that we must call the fever described, Sapremia, and not Septicæmia. That this distinction is now fully established as existing in fevers occurring during the puerperal state. Sapremia, is simply putrid infection, not a poison from an organism which goes on developing in the blood. He says that it is almost always the case that puerperal fevers are produced by one or another form of coccus, most often the Streptococcus.

At Bellevue and at Maternity Hospitals, says Lusk, I have had frequent occasions to witness febrile outbreaks among the patients in the lying-in service, which were instantly arrested by closing the ward and transferring the inmates to a wholesome locality. These outbreaks are not due to the transfer of the poison from patient to patient, or to overcrowding, but to what has been termed nosocomial malaria. When the disturbance produced by this nosocomial malaria is not arrested by change of locality, and the golden moment is allowed to slip by, the secretions of the patient affected become inoculable, and the epidemic spreads rapidly, and assumes continuously a more and more severe type. Apart from the nosocomial malaria of hospitals there is reason, as the examination of mortality statistics will show, to believe in the influence at times of certain general widespread atmospheric states which affect the entire community.

Though the argument is very strong in favor of regarding the genitalia of puerperal women as the exclusive point of entry of infectious materials into the system, it seems impossible, at the present time, to make all facts coincide with such a theory. I have the records of a number of cases occurring during an epidemic of puerperal fever, in which patients were either attacked with fever previous to parturition, or in whose cases the unusual length of labor, the frequency of post-partum hæmorrhage, and the imperfect contraction of the uterus immediately after confinement were signs of some abnormal influence exercised upon the economy at an early period of labor, previous to the existence of traumatism. That deleterious materials may find other channels for entering the system than a wound surface, is evidenced by the cachectic condition not unfrequently produced in physicians by two assiduous attendance in dissecting rooms and places in which post-mortem examinations are conducted. It does not yet seem quite time to give up the idea that, under exceptional circumstances, the respiratory, and probably the digestive, tracts may allow the passage of materials of a septic character.

Another and frequent source of puerperal fever is by direct inoculation. Any material of a septic character, introduced into the genital passages of a woman during or after confinement, may produce a general infection of the system. But the main point is that it is possible to trace epidemics of puerperal fever directly to carrying puerperal poison from patient to patient through the medium of attendants. In such cases, changes in wards and the most rigid sanitary precautions avail but little, as long as the affected *personnel* is continued in charge ; and unless this fact is fully recognized, all the cleverest devices in hospital construction will fail to prevent the occurrence of disasters. In epidemics this source of danger is especially to be guarded against, as septic poison is increased in intensity by successive inoculations. When a number of animals are poisoned, the one from the other, while from ten to fifteen drops of putrid blood were required to produce death in the first animal, one ten-trillionth part of a drop was sufficient in the twenty-fifth animal of the series, and in puerperal fever epidemics a similar augmentation in the deadliness of the poisons generated by patients, is observed. The nurses in hospitals and in private practice are usually the carriers of contagion.

With the view of ascertaining how far experience corresponds with the theory that puerperal fever owes its origin to poisonous materials obtained from dissecting rooms, and introduced into the genital canals by the hands of physicians attending cases of labor, Dr. Lusk made personal application to a number of gentlemen who have engaged in midwifery practice while performing the functions of demonstrators of anatomy in our medical schools. The

report of all is to the effect that they attended midwifery cases while at the same time attending to their duties in the dissecting room, and that their midwifery cases all did well. Of course there is no question but that it is a perilous experiment to pass from the dissecting room to a patient in labor without employing rigorous measures to disinfect the hands and all parts of the person brought into contact with the dead body. But it is well to call attention to the fact that puerperal fever is not due to any single simple cause, nor can it be effectively guarded against by a single precaution; and again, that cadaveric poison does not of necessity exist in every cadaver examined.

PATHOLOGY.—By J. RICHEY HORNER, M.D., ALLEGHENY CITY.—During parturition the soft parts are usually subject to laceration, more or less extensive, according to the relative size of the foetal head and the canal. These lacerations take place, generally, at the os uteri or the vulva. In the majority of cases resolution takes place at once, but sometimes the tissues ulcerate, giving rise to the “puerperal ulcer.” Frequently this is located on the ruptured perinæum, though it is sometimes found on the vaginal surface after the perinæum has entirely healed. The surface of the ulcer is covered with a brownish-green deposit, the surrounding parts are slightly inflamed, and the labiæ are œdematous. Under favorable circumstances granulation and resolution take place early, and no further consequences are noted. This is the simplest form.

At times the surface of the ulcer presents a decidedly diphtheritic appearance, which extends to the vaginal mucous membrane, or even down the thighs. There is intense œdema and erysipelatous redness of the parts.

By extension of the inflammatory process the uterine mucous membrane is involved, and may present a severe catarrhal inflammation—catarrhal endo-metritis. Ulceration and mortification may occur, and the whole mucous surface may be covered with diphtheritic patches. These are yellowish-brown in color, and from them masses of detritus may be scraped.

Where the whole surface of the endo-metrium is involved, there will be found either brownish particles or a smeary, chocolate-colored mass, involving either the superficial or the deep mucous layers, according to the amount of serous transudation. The uterus is found to be soft and pulpy, and its entire mass œdematous. In very bad cases pus, originating in the puerperal ulcer, fills up the uterine lymphatics, and at times, though very rarely, purulent salpingitis occurs.

The endo-metrium being inflamed, the uterine parenchyma becomes involved. We find œdema, imperfect contraction and

soft and pulpy tissues. If the inflammation extends deeply, it results in putrescentia uteri and perforation into the abdominal cavity.

The inflammation may extend from the connective tissue about the broad ligaments to the iliac fossa. Thence it spreads in different directions, though not usually affecting the bladder. In mild cases the œdema quickly disappears. If there is but little accumulation of cell elements, no trace of the disorder is left; otherwise, after fatty degeneration and absorption of the liquid portion, a hard tumor, composed of fine granular detritus, is formed, and this, under favorable circumstances, finally becomes absorbed. In very rare cases suppuration occurs. In many cases of parametritis we find thrombosis of the lymphatics without the inflamed area. This is favorable, as it prevents extension of the morbid process. Very rarely the ovaries are implicated.

Pelvic peritonitis is caused either by severe attacks of catarrhal endo-metritis, or from stretching and irritation occasioned by an associated para-metritis. There is a catarrhal exudation on the surface of the membrane of Douglas' cul-de-sac, the broad ligaments and the ovaries. This may be but slight, or so extensive as to result in formation of false membranes, by which adhesion of the pelvic organs occurs, and in consequence of this more or less serious derangement of these various organs.

The general peritoneal membrane usually shows signs of inflammation due to extension of the morbid process from the surrounding tissues. In mild cases, we find the peritoneum, and especially that part of it which invests the intestines, finely injected. Serous exudation occurs, and consequent adhesion of the abdominal organs. Or there may be a deposit of coagulable fibrine over the liver, intestines and uterus; the intestines becoming much distended, and the diaphragm displaced upward.

In the most serious and aggravated cases the exudation, instead of being serous or fibrinous, is purulent or of a brownish color and very putrid. The intestines speedily become black and gangrenous. When the poison has been directly conveyed by means of the lymphatics to the abdominal cavity, there are but few inflammatory symptoms. The cavity is filled with an offensive, thin, greenish fluid, the fibres of the intestinal and abdominal muscles become lax, and the subsequent formation of flatus produces abdominal distension. The peritoneum is covered with gangrenous patches, and very quickly becomes decomposed.

At times thrombi are formed. They are the result of an inflammation of the mucous coats of the uterine and pelvic veins. Generally those veins are affected which pass through portions of the uterus or surrounding tissues, which are infiltrated with purulent material. The endo-thelium undergoes proliferation and thick-

ening, and a blood clot is thus formed. This thrombus of itself is harmless. It is only when inflammation affects it that it becomes a serious factor. In this case degeneration and disintegration rapidly occur, and the emboli thus formed are carried into the general circulation. Wherever they lodge inflammation is set up, and abscesses are the result. To this source may be traced the pulmonary and hepatic abscesses so often the result of puerperal fever.

Puerperal septicæmia, a condition arising from the absorption into the general system of poisonous matter or organic material, which has become decomposed. It is similar to surgical septicæmia, and the local inflammations and pathological conditions above described are among its results. Any or all of the organs may be affected with inflammation during its course, and a constantly elevated temperature, almost the only symptom, be the result. This condition has been explained as follows: The blood, becoming loaded with septic matter, is capable of causing inflammation wherever it circulates, and as long as this matter continues to be absorbed, just so long will be kept up the local inflammations and rise of temperature. In some cases it has been observed that the serous membranes are most prominently affected; in others the mucous membranes, and in still others the lymphatic system. Abscesses may form in any tissue or organ, as a result of this pyæmic process.

At times the infection is so intense and the poison so active and abundant, that death occurs before any pathological changes have taken place. Autopsy shows only that the blood is dark and non-coagulable, and the various tissues are ecchymosed.

SYMPTOMS.—The first symptoms of puerperal fever generally appear on the second or third day, rarely later than the fifth day. The first noticed is slight chilliness affecting only the back; or there may be a well defined rigor. But the symptom which, if present on the second or third day, should incite careful attention and watchful care is *headache*—severe and persistent. Beyond this the symptoms vary greatly according to the organs or tissues involved, though there is always high temperature, enlarged spleen, arrested involution and sensitiveness of the uterus.

In order to have a clear understanding of this disease, we may arrange the symptoms under four distinct heads, viz:

- (a.) Parametritis and Pelvic Cellulitis.
- (b.) Perimetritis and Peritonitis.
- (c.) Metritis and Uterine Phlebitis; and
- (d.) Pure Septicæmia.

It is not easy to distinguish between parametritis and perimetritis, because the pain associated with the former is generally of such a character as to indicate implication of the peritoneum. In

fact it must be very rare for one form to occur independently of the other. Accordingly we have included under the head of parametritis all those cases which, from the *moderate* pain experienced, are more likely to belong there; while those cases which are attended with intense suffering with further evidence of peritoneal inflammation *which is limited*, we included under the head of perimetritis and pelvic peritonitis.

Parametritis, Pelvic Cellulitis.—The onset of this form may or may not be preceded by a rigor. The temperature runs up to perhaps 105° or 106° on the first or second day. It does not remain here, however, but remits or may intermit, and occasionally the temperature is at no time much above normal. The pulse usually corresponds with the temperature. When, however, the temperature remains very low and the pulse continues rapid, a very grave and serious symptom is presented.

Pain and sensitiveness is always present either on one side of the uterus or on the other.

An important diagnostic symptom, and one not easily distinguished is the presence of swellings formed from infiltration of the cellular tissue most often between the folds of the broad ligament. This is the pathognomonic symptom of the disease and is discovered by the side of the uterus, appearing to be only an unusual thickness of uterine walls, and in another case, there may be diffused exudation in the region of the internal os uteri, extending backwards and thus eluding the touch. Most often the tumors are limited to one side of the uterus but they may be on both, though differing in size, or they may be so low as to encroach on the vagina. At times, though rarely, the tumors occupy one iliac fossa or the other, and are to be distinguished only by abdominal palpation.

After a time, inspissation of the tumors takes place and in a few months, they are completely absorbed. Resorption is accompanied with hectic fever, but in favorable cases, the temperature soon becomes normal. Rarely, suppuration takes place and the abscess soon perforates the rectum, vagina, uterus, bladder, abdominal cavity of external abdominal walls.

Resorption does not always take place, however, owing to irritation, and then the tumor contracts, hardens, and becomes permanently fixed.

Pelvic peritonitis or perimetritis usually sets in on the second or third day, chilliness or rigors preceding the febrile condition. This is accompanied with pain and tenderness on *both* sides of the uterus. These symptoms yield in a few days to proper treatment or the inflammation may extend and *general peritonitis* follow. More often, however, this form of puerperal fever results from a pyæmic condition, and in this case, the pains resemble those of

pelvic peritonitis but are more slowly developed. The pain is intensified and diffused over the abdomen ; tympanitis is present and may be so great as to cause dyspnœa. The abdomen becomes excessively sensitive, the patient throwing off all clothing and lying prone upon the back with the knees drawn up so as to relieve tension on the abdominal parietes. The disease progressing, effusion occurs.

The lochia often continue undisturbed, or may become fœtid and diminished or altogether suppressed.

The secretion of milk is prevented if the attack has come on before the flow is established ; if afterward, the secretion is suspended and the breasts become flaccid.

As the temperature varies, it is not to be depended on. The pulse, however, is more constant, rising rapidly to 120, 130, or 160 beats per minute. In fatal cases, it becomes still more rapid, while the temperature finally descends.

The tongue is generally white in the centre, and red about the edges ; sometimes it is dry and brown in the centre, with yellowish or white fur at the edges. Vomiting of bilious, green, brown or black fluids occurs ; and there may also be diarrhœa. The urine is turbid, or high colored and scanty.

In fatal cases the countenance assumes an expression indicative of great distress, the forehead is cold and moist, the pupil dilated, the eyes lustreless and unearthly, and the extremities and finally the body cold ; and under this collapse, the patient sinks in a few hours.

Such is a description of a fatal case. When, however, recovery takes place, the diffused exudation becomes encapsuled, and the uterus agglutinated to the surrounding structures.

Metritis.—In this form, the attack may begin before delivery or almost immediately after, and it is then exceedingly malignant and runs rapidly to a fatal termination. Usually, the disease begins on the second or third day with chilliness or distinct and well defined rigors. The pulse is very rapid, full and soft. Distention with pain and sensitiveness of the abdomen may or may not be present. There is generally epigastric pain and tenderness with nausea and vomiting. Profuse sweating is a constant symptom, the sweat having a sweetish, pus-like odor. Thirst is very great, the tongue is flabby, broad and shiny, and covered with a yellowish coating. The countenance is pale and expressionless, or where the pain is acute, is anxious and covered with perspiration. Dark spots appear on the wrists and other parts of the body. The lochia are usually entirely suppressed but may continue undiminished, though after a time, they become fœtid.

As the disease progresses, diarrhœa may supervene ; the patient becomes nervous and anxious, the pulse is soft and rapid, the res-

piration quick, hurried and panting. This latter symptom, in connection with excessive distension of the bowels, is a very grave indication. Lactation is almost always checked, and may be entirely suppressed.

Uterine phlebitis is to be recognized long before the objective symptoms of external suppuration are presented. Dr. Meigs says :

"Hysterical or hysteroidal, and even maniacal symptoms, invariably mark purulent infection of the blood, and these affections in women recently delivered and assailed with fever, are really the exhibitions of that curious influence which pus in the blood or pyæmia, exerts on the nervous system. As the disease advances, the more palpable phenomena attendant upon pus formation in the veins are developed by the deposit of purulent matter in various parts of the body, and especially in the vicinity of the large joints. In such cases, we find swellings in the neighborhood of the articulations, erysipelatous blushes and large suppurations in the vicinity of the joints, or patches, of slough and gangrene form at the sides of the erysipelatous blushes."

We may have pulmonary abscesses, the temperature maintaining a higher and more constant level, and the pulse becoming small and rapid. The patient becomes soporous and slightly delirious, and the skin and tongue are hot and dry. The percentage of recoveries is small, though usually the fatal termination is postponed until the second or third week.

Pure Septicæmia.—In cases of intense septic infection, death may occur within thirty-six hours after the inception of the disease. The attack comes on very suddenly, the temperature rises rapidly, the pulse, at first full and vibrating, becomes small, hard and incompressible; the head aches violently, the skin is hot, the tongue white and moist. Soon the patient becomes delirious and comatose, and death follows.

In the commencement of this form of child-bed fever, the nervous system of organic life appears to be suddenly and seriously affected, as is shown by the general loss of vascular tone and of nervous power, by the disturbance of the vital functions, by the rapid exhaustion and by the sudden death. In these cases, the vital forces are, probably, overwhelmed by the intensity of the attack, but we have other cases of what might be termed pure septicæmia, following a more protracted course and yet evincing no decided lesions.

DIAGNOSIS AND PROGNOSIS.—WM. R. CHILDS, M.D.—Puerperal fever is not difficult to distinguish from other diseases. Its occurrence soon after delivery, the pronounced character and alarming rapidity of its progress is found in no other ailment of

the female sex. The acceleration of pulse, rigors more or less distinct, anxiety of mind (in some cases a sense of impending danger), will be the first symptoms of this dreaded malady. The pulse rising suddenly above one hundred, violent headache, any unusual symptoms, pains which differ in character from after pains, which, as a rule, gradually abate until, at the end of the third day, they have disappeared. The pain in this condition is aggravated by pressure and motion, and becomes more severe. These symptoms constantly increase as the disease progresses.

The secretion of milk may not occur, or, if it has shown itself, may be suppressed. The lochial discharge may cease or become thin, profuse and foul. The tongue is red, and thirst is ever present. The different forms of the fever have different manifestations. The puerperal metritis, puerperal peritonitis, uterine phlebitis, and that form in which the nervous system seems to have received a severe shock, and death ensues in a few hours.

The cases where, from putrescence of retained portions of placental tissue, we will have pyæmic complications to contend with, Simpson says, "death occurs after injuries or surgical operation from surgical fever, a disease consisting of a composition of co-existing fever, acute fever and acute internal inflammation, just as puerperal patients die of puerperal fever, a similar compound disease, consisting exactly like surgical fever, of co-existing acute fever, and acute fever and acute internal fever."

The prognosis of this malady is always unfavorable, but under the beneficent treatment of homœopathy, we have many notable cases of recovery.

GENERAL TREATMENT.—J. B. M'CLELLAND, M.D.—This important feature in the management of the most dreaded of all diseases unfortunately does not comprise much. Preventive measures, however, should be inaugurated to avert, if possible, this fatal calamity to the parturient woman.

The bed and bedclothing should be scrupulously clean, the latter well aired before the beginning of labor, and all soiled and bloody clothing, both of the patient and of the bed, should be immediately removed from the room after its termination; nor should the accoucheur be unmindful of himself. No examination should be made without first washing the hands and arms, thoroughly scrubbing and cleaning the nails, and rinsing in carbolyzed water. Some physicians change their whole attire before attending a case of labor. The bed-chamber should be light and cheerful, and an abundance of fresh air admitted. The lochia should be closely watched for any signs of fœtor, and at each visit pressure made over the uterine region, for the purpose of detecting the first evidences of undue tenderness. The genitalia

should be frequently bathed, and vaginal douches of two per cent-carbolized water employed three or four times in the twenty-four hours. Napkins, composed of navy oakum, covered with thin open-meshed muslin, should be applied to the vulva to receive the lochia, the tow acting alike as a disinfectant, as well as a preventive to the entrance within the vulva of septic germs. The pulse and temperature should be noted at each visit.

If, notwithstanding all the precautions possible, we are confronted with a case of puerperal fever, active measures must be begun at once. If the general peritoneum be invaded, then hot fomentations, frequently repeated, will be of great benefit, or hot turpentine stupes, 1 to 5 of water, will be found to be effective. After the subsidence of the acute symptoms, there usually remains a localized soreness, for which many good practitioners of our own school use cataplasms of mustard or a fly blister, or some even apply leeches, though how it is that that procedure can be of any service, when we consider a pump behind them forcing the blood to the spot, in larger volume than their microscopic mouths can possibly take away, has not yet been explained.

Venesection in all forms of puerperal fever was largely practiced a few years ago; even now it is not obsolete with some physicians. Twenty to twenty-five ounces was the quantity removed at one bleeding. It may be of interest to the present generation to cite the methods as practiced thirty years ago.

I will quote Professor Meigs: "The patient was seized with the fever when she was immediately bled to the amount of twenty-five ounces. The case continued under treatment nine days, during which time there were extracted from the arm forty-seven ounces of blood, fourteen dozen leeches were applied to the abdomen, four hundred and sixty grains of calomel and twenty-three grains of opium were administered, together with five warm baths, constant stupes, and occasional draughts of castor oil and turpentine." Notwithstanding all these vigorous measures, the Professor adds, the patient succumbed.

Even at the present day enormous quantities of opium are prescribed, simply for the peritoneal pain. Professor Lusk stated that a patient of Professor Alonzo Clark received the equivalent of 934 grains of opium in four days; a patient of Dr. Howard Pinkney was hypodermically injected with 13,969 drops of Magendie's solution in eleven days, and that a patient of his own was given the equivalent of 1,700 grains of opium in seven days. His own patient recovered, but he does not say what became of the other two.

Cold packs are also of great service in acute peritonitis. The patient is allowed to remain in them ten minutes at a time, then wrapped in a sheet without drying, and comfortably covered.

Were we to have the uterus or the pelvic cellular tissue attacked, hot vaginal douches of 80 to 90 degrees, carbolated, should be employed for five minutes every two hours ; *et* instead of carbolic acid, the permanganate of potash, or iodine might be added to the water. The latter is spoken of highly as an antiseptic.

When the lochial discharge is very offensive, and its appearance shows placental debris, then intra-uterine douches are necessary. But they must be used with great caution. C. Braun says : "We must protest against injections into the uterine cavity. Such meddlesomeness is more likely to do harm than good." Accidents, such as convulsions, shock and carbolic acid poisoning, from their use have been reported.

This caution, says Professor Lusk, is not intended to discourage the employment of intra-uterine antiseptics, in cases where it is strictly indicated. Thus he says, and truly, it would be folly in a fever due to the decomposition of placental debris, of shreds of decidua, of strips of membrane, or of retained coagula, or in diphtheritis of the mucous membrane, to treat the general symptoms, and neglect the local cause of difficulty. Before beginning the intra-uterine douche, the vagina should first be well washed out with a two per cent. solution of carbolic acid ; the continuous stream is much more preferable for the intra-uterine, or the vaginal douche either, than the interrupted. Its advantages are so apparent as not to require any explanation. In the treatment of pelvic exudations, the hot vaginal douche, warm baths and the application of flannels, wrung out in hot water, to the abdomen, help to relieve pain, and may even contribute to the absorption of the exudate. Where, however, it has gone on to the formation of pus, as indicated by the condition of the patient, the seat of the deposit must be discovered, and, if possible, evacuated. The local treatment is then similar to that of any abscess.

During the continuance of the acute symptoms of any of the varieties of puerperal fever, the diet will have to be carefully ordered. The patient should be given liquid nutritious food and cool water as much as she desires. After the acute symptoms have subsided, and we have evidence of peritoneal effusions, pelvic exudation, or the presence of pus, she will have to be well supported by rich, easily digested foods, milk-punch, egg-nogg, etc., etc. Puerperal fever seems to be now generally accepted by the profession as a form of septicæmia ; the administration of alcohol in some form in large quantities daily is recommended as an antidote to the evil effects of the poison upon the heart, and with good effect.

—PUERPERAL FEVER TREATMENT. C. C. RINEHART, M. D.—
Puerperal fever is a disease requiring immediate attention and

the most careful and pains-taking prescribing, and even with the utmost care and most skillful attendance, the mortality will be large.

In presenting the remedies I have thought it best to give them in the order of their usefulness, rather than in alphabetical order.

Probably the most useful remedy in the early stages is—

Bellad.—Violent pains coming and going suddenly ; pains in the abdomen as if clasped with claws ; abdomen distended and sensitive to the slightest touch ; pressure as though all the parts would issue through the vulva with constant ineffectual desire for stool (Nux vom. has the ineffectual desire for stool but does not have the sensation as though every thing would protrude). Lochial discharge suppressed, or vitiated and foetid, congestion of head with delirium, throbbing of the carotids ; face red ; light and noise are intolerable ; even a jar of the bed or persons walking across the floor causes suffering ; drowsiness with inability to sleep, or dozing with sudden startings.

Veratrum viride divides the honors with *bellad.* in the initiatory stages. It is useful in puerperal metritis or peritonitis. When the pulse is quick and weak, headache, violent throbbing, particularly frontal ; intense fever, restlessness, excessive pain, abdomen distended, skin cold and clammy.

Similar to *veratrum viride* is *Aconite*, which also has high fever, restlessness and painful and sensitive abdomen, but the skin is dry and burning, violent thirst for cold drinks, red and hot face, breath short, sighing and difficult respiration ; periodical and cutting pains through the whole abdomen.

Aconite is seldom useful save in the early stages and in the sthenic forms of fever.

Nux vomica is a remedy of great value, and is indicated by pain in the neck of the uterus as if bruised ; frequent desire to urinate, with pain, scalding and burning. Frequent ineffectual desire to defecate ; suppression or too profuse discharge of offensive lochia, with violent pains in the small of the back which are made much worse by attempting to turn in bed. Nausea with a desire to vomit or actual vomiting ; pain in the forehead above the eyes, with fainting spells ; dimness of vision, vertigo and ringing in the ears. Despondent, sleepless, or dreams frightful dreams.

The similarity between *nux vomica* and *Cantharis* is very manifest in some of the symptoms. Both have frequent urination with burning and scalding and passage of small quantities of urine, but in *nux vomica* the difficulty is spasmodic, largely due to spasmodic action of the neck of the bladder, and vesical irritability ; while with *cantharis* it is due to extension of the inflammation to the bladder. With *cantharis*, there is also burning in the uterine

region (tereb.). The vesical symptoms, however, are of the greatest importance in the selection of this remedy.

Bryonia.—Distended abdomen, sensitive to contact or motion ; headache as though the head would split open ; sitting up in bed causes nausea and fainting ; violent fever with burning heat of the whole abdomen ; lids and mouth dry and parched ; great thirst with desire for cold drinks in large quantities ; constipation, stools hard and dry as if burnt ; irritable, vehement or apprehensive for the future.

Rhus tox.—Offensive lochia, lasting too long or often returning (kreas.). Milk suppressed ; great restlessness ; cannot lie still, changes position constantly, which affords a temporary relief ; slow fever ; dry tongue ; extremities powerless, can scarcely draw them up ; pain worse at night and especially after midnight.

Arsenicum also has great restlessness but the prostration is more marked, there are burning, throbbing, lancinating pains, and accompanying the restlessness there is great anguish and fear of death. Thirst for frequent sips of cold water which aggravates her symptoms. Great prostration, sunken countenance, sallow or lived complexion, nausea, vomiting, dizziness, headache, delirium. Small, feeble pulse ; desire to be kept warm.

Baptisia has also extreme restlessness, but motion does not relieve. Septicæmia with typhoid symptoms ; foetid lochia, great prostration ; abdomen distended, fullness, flatulent rumbling. Feels as though vomiting would relieve. Sharp, shooting pains in the bowels ; urine scanty, dark red ; breathing oppressed on lying down, but without constriction of the chest. Indescribable sick feeling all over. Headache as though the head would fly to pieces ; thinks she could go to sleep if she could get the pieces together.

Secale corn.—Tendency to putrescence ; discharge of sanious blood, with tingling in the legs and great prostration ; urine suppressed ; offensive diarrhœa ; voice hollow, feeble and inaudible with difficult breathing. Burning fever interrupted by shaking chills ; cold limbs and cold sweat over the whole body. When the putrescent material is absorbed into the circulation, there is tingling and coldness of the extremities, and a condition of mind in which the patient has a mania for light, laughs, claps her hands, talks vociferously, tries to jump out of bed. The symptoms here would seem to strongly indicate stramonium, but stramonium would certainly fail. This condition is septicæmic intoxication, in which secale is the remedy, and is not a cerebral hyperæmia indicating stramonium.

Veratrum album has many symptoms similar to secale corn. It has the great prostration, suppressed urine, feeble, hollow and inaudible voice, offensive diarrhœa, cold limbs, and cold sweat

over the whole body ; but in *verat.* the prostration is due to rapid sinking of the vital forces, while that of *secale* is generally due to a gangrenous condition. *Secale* is a picture of septicæmia, while *veratrum* covers a condition of shock and consequent torpor of the vegetative system, with filtration of the liquid portion of the blood through the tissues, producing copious diarrhœa and vomiting and the cold, clammy sweat for which this remedy is so efficient.

Veratrum lacks the restlessness, anxiety and anguish of arsenic ; it is not characterized by any considerable pain. Its prostration differs from that of arsenic in that it is not greater than we would expect from the copious vomitings and diarrhœa, while that of arsenic is out of proportion to the losses.

Kreasote.—Stitches in the vagina proceeding from the abdomen, causing starting at every pain ; very offensive and excoriating lochia, which almost ceases and then freshens up again (*rhûs*). Urine fœtid, brown ; stools putrid, abdomen tense and distended ; labor like pains in the abdomen extending to the small of the back ; flushes of heat in the face ; painful sensation of coldness in the abdomen.

Terebinth.—Metritis and puerperal peritonitis ; lochia checked ; terrible burning in the uterus (*canth.*). Abdomen tympanitic and sore to the touch ; burning urination. Headache ; brown, dry tongue ; thirst ; nausea and vomiting ; pulse small and frequent, with general debility.

Lachesis.—Lochia fœtid ; urine suppressed ; abdomen tympanitic and sensitive to the least pressure ; cannot bear even the bedclothes to touch the uterine region. Uterine pains relieved by a flow of blood, but return soon afterwards. Always worse after sleep.

Hyoscyamus.—*Hyos.* is, in many of its symptoms, similar to *bellad.*, but has less congestion and fever ; the type is more typhoid ; the mental symptoms are peculiar and characteristic. The patient is bewildered by hallucinations that are only half real. She is quarrelsome, loquacious, has a tendency, in talk and action, to obscenity. She desires to be naked, and will not keep the clothes on the bed. The extremities jerk, the face and eyelids twitch ; delirium. It is especially useful when the inflammation has developed from emotional disturbances.

Stramonium may be said to stand between *bell.* and *hyos.*, having less fever than *bell.*, and more than *hyos.* The face is turgid with blood ; she awakens with a shrinking look as though afraid of the first object she sees ; she desires light and company ; is disposed to talk continually ; imagines all sorts of absurd things ; the hallucinations take complete possession, differing in this respect from *hyos.*, in which the hallucinations are only partial and bewil-

der the patient. The loquacity is not so marked, and there is no quarrelsomeness, but rather good nature.

Chamomilla.—The inflammation has been developed after a fit of anger. The mammæ are flaccid and empty; whitish diarrhœa; lochia scanty; abdomen distended and sensitive to contact; heat and great thirst; she is ill-humored and can scarcely treat her attendants with civility. There is the quarrelsomeness of hyos., but no delirium. The patient has her full senses but is unbearably cross.

Gelsemium.—Headache, the pain commences in the back of the head and spreads all over it. head feels enlarged; dizziness with blurred vision; the head feels sore both internally and externally: sensation of a band around the head. Sleeplessness or restless sleep with unpleasant dreams. Chilliness, languid, aching in the back and limbs; chills running up the back or begin in the hands; hands and feet cold, head and face hot. Fever heat with drowsiness; languid, wants to lie still, no thirst. Heavy, besotted expression of the face (bapt.). Face flushed and hot to the touch. Tongue feels so thick she can hardly speak. In many of its symptoms, gelsem. resembles bell., but it has not the febrile violence or suddenness of aggravation which characterizes bell.; is more heavy and stupid. The face has the heavy, besotted look of the bapt. patient, but the headache is different and it also lacks the restlessness of baptisia.

—CASES FROM PRACTICE. BY MARY BRANSON, M.D.—Light esteem seems to be placed upon homœopathy in obstetrics by many people, more particularly by the laity. Parturition is regarded either as a natural process, with little care needed other than that given by the midwife or nurse, or, if abnormal, a surgeon is accounted more suitable to complete the labor, little reliance being placed upon remedies.

Only a few weeks ago, being called from the city, I gave an obstetric case into the care of a substitute, but the lady's husband did not accept the change, remarking that, as his wife could not have the physician of her choice, he would make his own selection, having at all events a preference for a surgeon, at such a time. Again in choosing her accoucheur, the prospective patient will be advised to be certain to engage a physician who is especially good in labor cases, without reference to the school, as a good allopathist is better than a poor homœopath, etc. In truth, one can but feel the force of the comparison, though an unfair one. Let us see to it that this can not be said, for in addition to skill in attending a parturient patient, if the homœopathic remedy is discreetly administered, great good is accomplished, and the school and the medicine *will* make a difference in the choice.

Mrs. C., although strictly homœopathic in her family, held

always to the one old school physician in each of her nine confinements, saying she did not like to make any change, Dr. L. was so kind to her, and the "regulation" dose of oil that he always administered on the fifth day did her no harm. Her labors were tedious and severe, but nothing could prevail upon her to change her school at this time, "for what could medicine do in a natural process?"

Mrs. M. had four children under the old school; she was ailing during her entire pregnancy, discouraged and exhausted. When pregnant six weeks with her fifth child, she placed herself under the care of a homœopathic physician. Through remedies carefully selected, her indigestion ceased, she became perfectly well, and her labor was natural, with excellent recovery. The sixth pregnancy, also under homœopathic treatment, was attended with equally good results. This does not imply continued dosing, another slander our school has to bear, but only the careful prescribing for symptoms as need may occur. "Homœopaths are always dosing, the medicines are easy to take, and do no harm, and that is the reason I am disgusted with it," was said to me the other day. This objection needs to be guarded against, but, on investigation, it is a question whether there *is* more dosing in the new than in the old school. There, it is paregoric, laudanum, nitre, mustard, citrate of magnesia, and quinine (taken almost as a food); or, worse than all these, the deliciously tasting tonics, mostly alcohol, taken for every little ache or pain, or feeling of lassitude. Then, too, the remark that the "homœopathic remedy will do no harm, even if it does no good," is a false one. It does not destroy life directly, but it disturbs the system, renders it torpid in responding to correct remedies, and gradually undermines the health.

In one year, there occurred in an allopathic hospital five deaths from puerperal fever, and nearly every parturient patient attended there during that time, had high pulse, pain, tympany and many unsatisfactory symptoms. The disease took various forms of blood poisoning: peritonitis, metritis, septicæmia, abscess, phlegmasia alba dolens, phlebitis, typhoid, malarial, diphtheritic, etc. Scrupulous care in nursing and disinfection was taken in every case. Complete quarantine was enforced, prophylaxis, antiseptis in every point was followed. Antiseptic vaginal injections were depended upon from the day of confinement. Throughout the entire period it was accounted an actively contagious or infectious malady. The physicians attending a case of fever did not see the other patients, and the physician on duty in the obstetric wards did not enter the fever district. Quinine was the main dependence, fifteen, twenty, and up to forty grains in the twenty-four hours, but with generally unsatisfactory results. When im-

provement occurred, it could not be traced to the quinine, and it was during my experience in this epidemic that I looked longingly to the other school for something better, and found it ! The satisfactory results in the homœopathic school that are manifest to the writer, especially in the post-partum period, would suggest the idea whether or not the dose of *arnica*, invariably administered to the exhausted patient, after a protracted or unnatural labor, has aught to do with bringing about this happy condition.

The following quotation from an address by the late Dr. H. N. Guernsey, gives some valuable statistics taken with conscientious care from reliable sources.* "In allopathic treatment of puerperal fever, phlebitis, phlegmasia alba dolens, etc., the loss within the puerperal month is thirty per cent., or three hundred per thousand. In homœopathic treatment, pure and simple, in the same disorders, only two per cent., or twenty per thousand. In puerperal convulsions (real eclampsia), allopathic treatment has a mortality of twenty-five per cent. or two hundred and fifty per thousand. In homœopathic treatment, pure and simple, we have a loss of only one and a half per cent., or fifteen per thousand. In puerperal hæmorrhages post-partum, the allopathic fraternity sustains a loss of sixteen and three quarters per cent., or one hundred and sixty-six and two-thirds per thousand. The loss from the same disorder under homœopathic treatment, pure and simple, is only one-twentieth of one per cent., that is, one in two thousand. The average mortality from all causes, within the puerperal month, from allopathic treatment, is one per cent., or ten per 1,000. . . . Our statistics prove beyond question, that our mortality does not reach one-fifth of one per cent., less than two in a thousand."

With such record before us, one can not but place dependence on our homœopathic drugs. Two or three cases under my own observation, have presented points of such deep interest, I would like briefly to note them, although I regret with the first being unable to give her later treatment.

Mrs. N. has light complexion and excellent health ; is intelligent and bright, with active temperament, and marked freedom from nervous symptoms. Had had one child, labor natural, with the exception of severe laceration of the perineum. She had some dropsical symptoms previous to parturition, but not serious. The perineum was repaired by a secondary operation. Her second pregnancy was natural up to September 11th, the beginning of her eighth month. She was away all summer, and on her return, early in September, called me in to see if she was "getting on

*See a treatise by H. N. Guernsey, M.D., read by invitation before the New York County Homœopathic Medical Society, November 13th, 1878, published in *New York Medical Times*, for January, 1879.

well." She then had some general dropsy and a troublesome leucorrhœa. These were all her symptoms. On the 20th she became very restless and nervous, not lying down a half hour all night. She suffered sharp pains in the region of the stomach, like indigestion. Nux relieved these symptoms, but her appearance at this time was not satisfactory. The dropsy was more marked, even sufficient to change the expression of her face. She complained of dimness of vision, light was clear to her, but objects were misty, "as if looking through water," was her comparison. This was the very fact, because an effusion of water was easily apparent over the whole cornea, and the ophthalmoscope revealed marked infiltration. Apis³ in water was administered. Her nights continued to be restless and distressed. On the 22d, her condition was alarming. The nervous symptoms and dropsy were increased. She could neither eat, sleep nor lie down. Her limbs were enormously distended, also abdomen and chest; everywhere the dropsy was severe. Heart action was turbulent, one hundred and forty pulsations or more *per* minute, and often beyond counting. The sounds were irregular, a marked click with the second beat; respirations were forty to sixty *per* minute, and agonizing. There was extreme tension of the body, the muscles were drawn like cords with the effort of gasping for breath. Her eyes were dry and glaring. She called constantly for air, but felt as if there was none to breathe; said she "must relax," the consciousness of extreme tension being so unbearable. Every joint was stiff, and she sat perfectly erect in a chair, with her feet slightly elevated, then, as the attack lightened, she would lean forward on something in front of her, and doze a few moments. There was slight relief in the morning, but after an afternoon doze, or in the night, the violence of the paroxysms was reached. The urine was loaded with albumen, some pus and blood, one pint was voided in the twenty-four hours. The diagnosis was easy, "acute tubular nephritis, with irregular convulsive seizures, complicating pregnancy." Lachesis was administered but with no apparent relief. Counsel was called, and premature delivery suggested, but not considered justifiable or safe. On the night of the 23d, she was taken worse, a physician within easy reach was summoned, who gave her first nux for sharp pains, following the taking of a little nourishment, then succeeded with apis. On the 24th, there was a slight change for the better. On the 25th, the convulsive paroxysms were less, but the patient showed signs of exhaustion, and the heart sounds continued bad. Face quite as puffed up, and weary, eyes staring. As the patient lived out of the city, and her friends were continually obliged to call in the neighboring physician, it seemed better to give up the immediate care of the patient to him, though I still held an interest in the case. Apis was the remedy mainly de-

pended upon, in different potencies. On the 29th, she was better, and for two days continued to improve, so that she could lean back in her chair, and even lie down for a short time. On the night of the 30th, she had excruciating pain, in the left lumbar region, which though prescribed for, was no better, until a sudden movement of the fœtus relieved pressure. The child, for three days previous to this, had shown no sign of life. The following day she had apparent labor pains for an hour, but they passed off. On the 2d of October, at four o'clock in the morning, these returned, and an hour later the infant was born, one month before term. Though immediately summoned, the doctor did not reach the house until the head of the child was expelled. The infant was dead, and had been for several hours. No laceration occurred and the symptoms were relieved, all pointing to a rapid convalescence. This, however, did not continue, the uræmic symptoms were slow in yielding, hemiplegia occurred, and her condition was again critical. All yielded later to remedies, and she recovered her former health, though her speech returned slowly, and her brain for a long time did not act so quickly as previous to her illness.

The following case of a brave little English woman presents some points of interest.

Mrs. —, æt. 23, married two years, mother of one child. Healthy, fair, ruddy, has had no serious illness. At the date of this illness, August 1st, she had been in America two months, all of which time she had suffered with diarrhœa; she was pregnant, her labor was due in October; the diarrhœa was not severe, but of a dysenteric type. In the latter part of July, when she sought advice, readily yielded to *mercurius vivus*, which was clearly indicated. On Wednesday, August 8th, diarrhœa again occurred, but of a different character. The discharges were profuse, watery exhausting and painless, and accompanied with vomiting. Her physician was not summoned until Friday, August 10th. Already her condition was appalling, it was scarcely possible to recognize her, she was cold, pinched, blue about the lips, eyes sunken, face bathed in cold perspiration; the emaciation was extreme. An ordinary sized bucket was full of a brown, offensive liquid, which had passed her bowels during the previous night. Every article of food or drink was instantly vomited. She suffered from intense burning of mouth and throat, which were swollen, red, and angry, in appearance; the entire mucous membrane felt as if raw, and looked so. The burning in her stomach was as if some violently acrid or corrosive substance had been swallowed. That the patient was laboring under a profound poison of some sort was apparent, and from the acute local symptoms, the possibility of an overdose of a strong drug was suspected, either accidentally or

willfully taken. She had been discouraged, because they had not prospered in this country, was home-sick, and distressed at the prospect of another child—but from the closest questioning, there seemed no evidence of such a cause. Then investigation was made as to poisoning from tin cans, etc., but no light was thrown on the case. A careful vaginal examination was made, but with negative results, there was a scant, pus-like discharge, with a rather heavy odor, from the vagina, but no other evidence that the foetus was giving rise to the trouble. The patient thought she felt the child move, but this was questioned at the time. The indications for various remedies were marked, *caus.*, *phos.*, *ars.*, *bell.*, *nerat.*, were thought of in rapid succession, but *veratrum* was administered; it modified the discharge from the bowels. After this, *ippecac* relined the vomiting, which had not yielded under *verat.*; but her condition was not encouraging, the weakness and prostration continued. Milk was the only nourishment taken, and it was but seldom retained. She would not speak unless spoken to, noticed nothing, cared for nothing. Swallowing was accomplished with great effort, owing to the swollen and sore condition of mouth and throat. She appeared almost comatose. At this stage, *arsenic* was administered and continued. The cold, pinched face, the dry, burnt condition of mouth and throat, with the persistent burning in the throat, and other symptoms, decided the choice. From this period until her ultimate recovery, no other remedy was needed, except at one time *belladonna* as indicated, but the main reliance was placed upon *arsenic*. Her friends gave up all hope of her recovery, had the priest brought, altar set up, candles burning, etc. This general condition continued for about two weeks, with the daily thought that an abortion might occur at any time, then came a change for the better, slight, but perceptible. She noticed what was going on about her, the drawn expression passed away, and "a look of life came over her." The next gain was her asking for food; only milk, broths, and cold water had as yet been given. In ten days from this date, she had so far recovered, as to move about the house, go down stairs, and even walk out into the air a few times. On [the last day of August, while sitting comfortably in an easy chair, and counting herself well, without pain or other premonition, she passed a dead foetus, with all the appendages, in an entirely decomposed state. It appeared about five months, as far as was discernible, but the condition prevented much examination. It was, as the nurse termed it, "a great rotten mass." She was hastened to bed. The lochia was natural, there was milk in the breasts, no unfavorable symptoms occurred, and she made a rapid recovery.

—HÉGAR'S SIGN OF EARLY PREGNANCY. By J. NICHOLAS

MITCHELL, M. D., Philadelphia.—To the obstetrician, and gynæcologist also, it often becomes a matter of the utmost importance to be able to determine pregnancy in the early weeks. The impossibility of determining this fact at such an early period has been termed the opprobrium of the obstetrician, and most authorities have stated in the past that a positive diagnosis of pregnancy could only be determined by the sounds of the foetal heart.

To arrive at some certain sign then, has been the constant study of many, but though many signs have been discovered, none of them has been found invariably correct in all cases, unless this new one proposed by Hégar will bear the test of many investigations. Like the symptom of absence of menstruation, others, such as the discoloration around the nipples, the kysteine in the urine, and the slate or purplish color of the vagina, have been found to be simply presumptive signs, since, unfortunately for the purposes of diagnosis, they are found in other conditions besides that of pregnancy.

Again, other methods that have been proposed and not practicable in general practice, such as the proposal to apply the principles of the telephone, so as to hear the feeble sounds of the foetal heart earlier than can be done by the ordinary method.

Others have proposed methods which are too dangerous to follow, even if the certainty of the test be allowed, such as Gehrung's proposal to pass the sound into the uterus, to recognize thereby the sensation imparted to the instrument when it touches the foetus; or Fry's discovery that the temperature of the cervix is one degree or more above that of the axilla during pregnancy. If this same variation was found to occur between the vagina and axilla it would be a useful sign, but unfortunately such is not the case. There is too much risk in passing anything into the cervix, however, to even put this sign to any great trial. The sign which has been offered by Hégar has, so far as my reading goes, proven of more value than any other, since all who have written upon it and have learned to recognize it, are enthusiastic about it.

Dr. Reiul, formerly assistant to Hégar, says, in twenty-two cases it was missed but twice, and discovered as early as the fifth week.

Dr. Compes, assistant to Hégar, has reported six cases.

Dr. E. H. Grandin says: "I am inclined, from a limited experience, to consider it infallible." He reports eighteen cases. Dr. E. S. McKee reports two cases. In one, from the absence of this sign, he made a diagnosis, which time proved to be correct, that the patient was not pregnant, and in another, diagnosed pregnancy by the presence of this sign.

To these, I have to add nine cases where I found this sign present and where I diagnosed pregnancy, and time has proven

these diagnoses correct. In two of these, pregnancy was not at all thought of, nor was this sign particularly sought after. This has made it, to me at least, a symptom of greater value, since often when one is looking for a peculiar sign or symptom, and has his suspicions aroused, imagination plays a great part.

Besides these, there were two others of great interest. One of them had gone two weeks over her time, and supposed herself, from that alone, to be pregnant. During my absence from the city, she was taking with severe flooding when in the street. Finding me absent from the city, she sent for an allopathic physician, who checked the hæmorrhage, and said that if she had been pregnant before, she certainly was not so after this hæmorrhage. Upon my return home, a week later, she sent for me, and finding this sign of Hégar's present, I diagnosed from that alone that she was pregnant. In a week's time she had another severe hæmorrhage, which was likewise stopped, and since then there has been no further trouble, and time has proven that she was pregnant.

In another case, a physician brought his wife to me for examination. She had passed her period but a few weeks. He said that he was sure that she could not be pregnant. I examined her, but could decide nothing. She had no symptom to go by except the absence of menstruation. I advised him to bring her to me again a few weeks later, which he did, and then informed me that he had passed the sound into the uterus since I had made the first examination, as both he and his wife were sure that she could not be pregnant, that a week had gone by, and that as yet she had no discharge. She had none of the usual signs of pregnancy. Her breasts had not changed in color; she had no nausea nor any other symptom. Upon vaginal examination, I found Hégar's sign, and by it alone diagnosed pregnancy. Some two weeks afterwards she miscarried.

It is not necessary to go into the details of all the cases; it is sufficient to say that the diagnosis of all of them was made between the fifth and eighth week. Since it may have happened that the description of this sign has been overlooked by some, I have thought it well to describe it.

During the first few weeks of pregnancy all the change that occurs in the uterus, occurs in the body. From the hyperæmic condition of the uterine body, due to the attachment of the impregnated ovum, it enlarges, and this enlargement is most marked in the antero-posterior diameter; furthermore, the density of the uterus becomes markedly decreased to the touch. As a result of these changes, the uterus loses its usual pear shape; the outline of the body is no longer that of a gradual curve from the fundus, lessening gradually as it approaches the cervix; on the

contrary, as Grandin expresses it, "the body bellies out over the cervix in all the transverse diameters, in particular, antero-posteriorly, and the organ, instead of being pear-shaped, resembles very much an old-fashioned, fat-bellied jug."

Of course, to determine these changes in the uterus by the touch, requires more or less familiarity with the feeling, shape and size of the non-pregnant uterus, and also with the uterus when changed by disease.

The finger will generally note it best in the anterior cul de sac of the vagina, the sudden bulging out of the body around the cervix being most readily noticed there, from the normal anteversion of the uterus. The other hand being placed upon the abdomen and the uterus felt between the two hands, the softened resilient condition of the uterus will be felt, the slight sign suggestive of fluctuation. Of course, to be perfectly satisfactory, it is best to empty the bladder before attempting the examination.

—PUERPERAL FEVER—CLINICAL CASES.—BY S. W. S. DINSMORE, M.D. SHARPSBURG, PA.—The appended cases are submitted without comment, as no adequate cause can be assigned by the writer which would produce this disease, so puzzling to the physician and generally so fatal to the patient.

During the early part of March I was called to attend but two obstetrical cases, a primipara March 4, exceedingly difficult to deliver. It was impossible to prevent the small forceps from slipping, and after the second attempt I applied Wallace's long forceps, and with no little exertion delivered the child.

Four days later there was considerable metritis, which, with hot applications and the indicated remedies (bell., cham., etc.), gradually subsided, the patient making a complete and rapid recovery.

The second case was natural, and recovered promptly without medication.

At 2 A. M., April 31, delivered Mrs. W. of a male child, her first confinement, followed by prompt recovery.

At 8 P. M., of the same day, delivered Mrs. B., æt. 25, of her second child. Labor lasted about one and one-half hours. Both mother and child seemed in good condition, and remained so until Sunday, May 2, when she took a chill, followed by a raging fever. Temperature 104°, discharges, etc., suppressed. When discharges reappeared they were very offensive, great distention of the abdomen, sharp, lancinating pains, which condition continued until death, which occurred at 11 A.M., May 11. The patient was of good constitution, and had a history free from hereditary predisposition to disease.

At 1:15 P. M., May 1, delivered Mrs. McD. of a female child,

weight twelve pounds. Labor natural; shoulders difficult to deliver; no other difficulty attending. Next morning, Sunday, she began to vomit green, offensive matter, with simultaneous movements of the bowels. Matter thrown up changed to a yellowish hue, still offensive; pulse became rapid and feeble; temperature ran up to 105° , with alternate chills and hot sweats. Tympanitis came on rapidly, with delirium, gritting of the teeth, eructation of wind, and occasional vomiting of greenish-yellow, bitter fluid. Although carefully nursed and having apparently the indicated remedies, she grew rapidly worse, and died at 6 P. M., May 11th, five days and three hours after the child was born.

Sunday, May 2d, Mrs. V., a delicate, fair-haired and fair-complexioned woman, was delivered of her third child. Labor tardy but natural. With the exception of a slight engorgement of the breasts, a very satisfactory recovery.

Monday, May 3d, 2:15 A. M., Mrs. B., a healthy, fully matured woman, was delivered of her first child. Labor natural, lasting about one hour after the rupture of the membranes. Monday night, had chills, followed by vomiting of greenish, bitter fluid. Temperature 105° , reaching this point but one other time. On the evening of the 6th had nervous twitchings, excessive tympanitis, sharp, piercing pains, suppression of milk and lochia—a condition similar to that previously recorded of case number three. She died at 5 P. M. of the 8th, a week, lacking a few hours, from the time of confinement.

At 1:25 A. M., Mrs. K., a primipara, æt. 25, well developed, apparently in robust health, was delivered two weeks in advance of the time of expectancy. She had heard nothing of previously recorded cases. Labor normal, lasting about two hours; after-birth loose in vagina. At 10 A. M., Thursday, found temperature 102° , pulse 120; skin hot and bathed in sweat; discharge free, with considerable after pain. At 8 P. M., temperature 105° , pulse 148; nervous; belching of wind in large quantities; abdomen tympanitic and exceedingly sensitive to touch; pain under the ribs; timid and fearful; pulse never lower than 130 or temperature below 102° . Death occurred at noon of the 12th.

At 9 A. M., May 8th, Mrs. D. was delivered of her second child. After waiting fully one hour after the os was dilated, with no advancement of the head, the short forceps were applied, and very easily delivered of a very large child, being her second. She said the first labor lasted ten hours. Sunday, at 10 A. M., she began vomiting greenish fluid. Temperature 101° ; fever; after pains, severe; discharge free; eructations of wind, with tympanitis; great thirst; hot sweat and quick pulse; bowels loose. Patient was tolerably easy, but the distention of the abdomen gradually increased. Fever moderate until about 9 A. M. of the third day,

when she began to vomit a greenish, watery fluid, continuing at intervals of a few minutes, until two chamberfuls had been thrown up.

At 9 P. M., skin cold ; perspiration profuse : pulse at the wrist not perceptible ; vomiting continued, nothing remaining on her stomach. Verat., camph., tart. emet., ipecac., lime water, were given without any benefit whatever. Lochial discharge free, not offensive ; tympanitis not great ; temperature 96°. Died at 7 A. M. of the 12th, lacking two hours of four days from the time of parturition, being the fifth death within ten days.

One case, number four in the order of delivery, making a complete recovery without any feverish or abnormal symptoms.

It may be added that, topographically, all were some distance from each other. No unsanitary surroundings can be assigned as contributing causes. All were treated antiseptically ; the nursing, while not professional, was equal to the average family care usually given, and all in circumstances of life free from want or distress. In view of these facts, the writer confesses his inability to give a satisfactory reason for their simultaneous development.

Remedies used were bell., china, ars., apis, verat. vir., verat. alb., camph., iris., hyos., chiefly. All the children have since died.

—A CASE OF PLACENTA PRÆVIA. BY W. J. MARTIN, M.D., PITTSBURGH.—Early on the morning of June 22, 1886, I was summoned in haste to Mrs. R. Upon arriving at the house I found the patient very pale and weak, and noticed that she yawned frequently. Was informed that she had been flooding profusely for several hours, a steady flow of bright red blood. I immediately administered a dose of ipecac. and in a short time there was a wonderful change in the condition of the woman. The color returned to the lips and face, her voice became stronger, and she said the flooding was "checking up." The history of this case is briefly as follows : She is now pretty near term ; for three months back, she has been having attacks of hæmorrhage from the womb, occurring suddenly, unexpectedly, and without any provocation whatever, sometimes coming on while she was sitting quietly on a chair. The blood was always bright red, fluid. My diagnosis had been from the first placenta prævia, and I looked forward to a serious time. She was very anxious to have a living baby (this was her first pregnancy) and I was very desirous of being the means of assisting in the accomplishment of the desired end. These frequently recurring hæmorrhages were always speedily controlled by millefolium. The evening prior to my being called to her, the husband got medicine at the office, saying she had another of the flooding spells. I sent millefol., which I was told afterward, stopped the

hæmorrhage for several hours, but as it returned with greater severity and accompanied by pain, they thought best to send for me. I now made an examination, and found the os patulous and dilated by about the size of a half dollar, and the placenta presenting. By running my finger around inside the os, I could feel nothing but placenta anywhere except a narrow space on the right side, where, by considerable effort, I could reach high enough up to touch the foetal head. Thus we were favored by not having a complete central implantation. My plan of procedure was at once decided upon, viz.: to hasten dilatation by introducing my fingers in the shape of a wedge, and as soon as I could get the hand into the uterus, turn the child and bring the legs and feet out. A messenger was sent for my friend, Dr. Briggs, whose office, fortunately, was not far distant. The Doctor quickly responded, and upon examining the case found the conditions as I have stated. After placing the patient in a favorable position, Dr. Briggs proceeded with the administration of the chloroform.

I found the introduction of my hand to be not very difficult, the grasping the feet and bringing [them down was 'more so, but yet it was accomplished quite speedily; and here I had intended to let matters rest (as all hæmorrhage was at once stopped), and await further dilatation and expulsive pains, but I was surprised as well as vexed to find a coil of the cord around one of the legs, and it was not pulsating. Still my desire to make the result in the case the best possible, spurred me to try to get the child delivered at once. So wrapping a cloth around the ankles, to keep my hand from slipping, I steadily pulled as hard as I dared, until I had the body delivered, and here it seemed inclined to stick, until Dr. Briggs, by placing his hands on the woman's abdomen, got his fingers down behind the foetal head, and, as it were, expressed it from the uterus.

The child, we need hardly say, was pale and breathless, but its heart was still beating, though but slowly and feebly. Every thing was in readiness, and while I looked after the mother Dr. Briggs went to work with a will to resuscitate the child. He worked diligently and patiently but to no avail, the heart finally ceased to pulsate.

With the mother every thing went well, and in two weeks she was up. The treatment in her case consisted simply of perfect quiet and cleanliness and the administration of the indicated remedies. Many, no doubt, would have used antiseptic injections, but this is a practice I have never pursued except when there were conditions present requiring it. The indiscriminate use of these injections, or their use in all cases, as advised by some, I can not but think is useless, and sometimes, perhaps, worse than useless.

This is the second case of placenta prævia that I have seen. The first case, which was some eight years ago, was managed after the manner directed by Guernsey in his work on obstetrics. The membranes were punctured by a catheter thrust through the presenting after-birth, and the liquor amnii drawn off. But instead of pains coming on, the little pain there had been, ceased, and the hæmorrhage was not modified in the least. The woman bled and bled. Stimulants and ergot were frequently and freely administered. The os dilated very slowly and the pains were almost nil. As soon as it was at all possible to introduce the forceps the placenta was torn and the child delivered in that way. It was dead. The woman was thought to be dead or dying, but she slowly rallied and made a very tardy, though perfect convalescence.

The two cases lead me to the conclusion that the method by turning is by far the preferable one, though Guernsey, an author for whom I have great respect, says that "suffering entailed upon the woman by this method, and the very great mortality of both mothers and children following its practice, sufficiently condemn it."

As regards the suffering, that can all be gotten over by the use of chloroform, and there is no reason why the mortality should be great, or hardly any to the mothers—of course, the child's chances are not extra good. And the statements that "almost invariably after placenta prævia has been treated by the withdrawal of the liquor amnii through a catheter, the os uteri dilates in a natural manner until it is sufficiently enlarged to admit of the passage of the child," and that as surely as the liquor amnii flows off slowly "so surely will the hæmorrhage cease," must I think be taken *cum grano salis*.

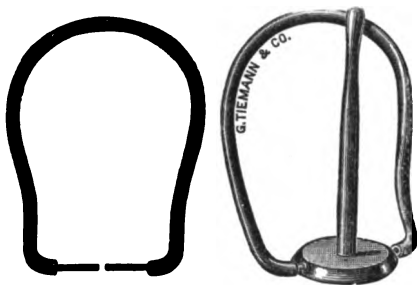
SOCIETY NOTES.

Among the transactions of the *Obstetrical Society, of New York*, we find an interesting report from Dr. H. M. Sims (son of Dr. J. Marion Sims), on the subject of retroversion and its treatment. Dr. Sims presented a hard-rubber pessary which, it seems to us, will prove an admirable assistant in the treatment of this—sometimes—vexatious disease. In cases where the ordinary pessary can not be employed—short cervix uteri—this instrument can exert a force in a direction favorable for the maintaining in position of the organ that often proves a stubborn affair to the operator. We give, in brief, an extract of the report as made by Dr. Sims and the discussion :



Dr. H. M. Sims exhibited a hard-rubber pessary of his own devising, adapted to cases of retroversion in which the cervix uteri is very short. It consisted of a straight stem, to the base of which was attached a ring having the shape of the posterior half of a

Hodge - pessary. At the points where the ends of the ring joined the base of the stem were two peculiar bends, or shoulders, of such a shape that when a downward pressure was exerted upon the stem, the ring was tilted upward.



The instrument was adjusted by exposing the cervix through a Sims'

speculum, pulling the anterior lip downward and forward, and at the same time slipping the end of the stem into the os. As soon as the weight of the uterus rested upon the disc forming the base of the stem, the ring was thrown forward against the symphysis, where it took its *point d'appui*, pressing the cervix backward, and thus anteverting the uterus.

Dr. Sims explained that the instrument known as the uterine elevator had suggested to him the principle adopted in the pessary. He had invented the latter a year and a half before, but wished to test it thoroughly before offering it to the profession ; he had used it in a number of cases, and always to his perfect satisfaction.

EDITOR'S TABLE.

—MICHIGAN, THE BANNER STATE.—During the last year the Michigan Homœopaths have organized six new County Medical Societies. They have adopted the plan of organizing one local society in each congressional district, and to this end have already completed six districts. The Michigan Homœopaths, with that grand old leader, Doctor A. I. Lawyer, at their head are laying siege to the Insane Asylum, which was stolen, by and through the treachery of the Governor, from them last winter. The OBSTETRIC JOURNAL wishes these energetic and aggressive workers, in the interest of homœopathy, every success.

—The Editor takes pleasure in informing his friends that he has had conferred upon him the honor of a Fellowship in the British Gynæcological Society.

—The *Archives of Gynecology, Obstetrics and Pædiatrics*, New York, series of 1886 just completed, has met with such warm encouragement, the publishers have decided to issue monthly; and commencing January, the parts will so appear, instead of bi-monthly as heretofore.

—It is with pleasure we note the fact that our colleague, Dr. T. Griswold Comstock, of St. Louis, has been honored by the St. Louis University with the degree of Ph. B. Accept our congratulations.

—The article on Cocaine by Dr. O. S. Runnels, published in the July issue of this journal, was read before the Indiana Institute of Homœopathy, a fact of which mention was inadvertently omitted.

—When selecting a remedy for uterine, vaginal or ovarian disturbances, consider, first, the regularity, character and amount of the menstrual flow. Second, the leucorrhœa; color, amount and character. Third, pain; its character and locality. Fourth, personal characteristics of the patient; then follow with a complete and exhausting history. Take plenty of time for the first visit.

—For vesical irritation in the female, always bear in mind that fissures of the rectum, rectal irritation, and even an accumulation (oftentimes habitual) of fæcal matter, will be found the seat of the trouble. Rectal ulcers are also prolific of a great deal of reflex disturbances, sufficient sometimes to deceive the physician into the belief that he has a genuine case of cervical or uterine disease to treat.

—*Physical examination* of the young girl or maiden lady who has a complete and firm hymen, should be performed with the greatest discretion and carefulness. If possible, always examine for uterine deviations through the rectum. With little practice the physician can determine almost as well through that source as the vagina.

—Never make light of the most insignificant symptom given you by a lady patient at her first visit. Be sure that you have your patient's confidence before you commence to treat her locally. Always make her an interested party. Never be guilty of undervaluing local treatment, or of undercharging either. If circumstances prohibit your patients from paying a good fee, let them learn to appreciate the fact that you charitably give them the difference. Patients, as a rule, appreciate gynecological treatment in proportion to the amount paid. Our country surgeons do not charge enough for gynecological practice to give character to their work. This truth we have seen illustrated many times. If the physician appreciates his work, he will charge for it. If not, the patient will soon detect his dishonesty, for the practitioner is dishonest who makes a local examination or treats a lady locally

without he is confident there is a good reason for it, and she will not only detest this physician but others. Raise the dignity of gynæcological practice and charge for it too.

—AMERICAN INSTITUTE for 1887. The following list is announced in advance. The Bureau of Obstetrics. Millie J. Chapman, Pittsburg, *Chairman*. G. B. Peck, Providence, R. I., *Secretary*. R. N. Foster, Chicago; Emily Pardee, S. Norfolk, Conn.; J. B. Waite, New York; J. N. Mitchell, Philadelphia; C. E. Fisher, Austin, Tex.; C. G. Higbee, St. Paul; W. Wesselhoeft, Cambridge, Mass.; Hugh Pitcairn, Harrisburg, Penn. Subject: "Accidents and Diseases that complicate Gestation and the Puerperal State."

BUREAU OF GYNÆCOLOGY. S. P. Hedges, Chicago, Ill., *Chairman*. Philip Porter, Detroit, *Secretary*. L. A. Phillips, Boston; R. Ludlam, Chicago; M. T. Runnels, Kansas City; J. C. Wood, Ann Arbor; O. S. Runnels, Indianapolis; B. Frank Betts, Philadelphia; S. J. Donaldson, New York; Edward Blake, London. Subject: "Uterine Disorders: Methods of Treatment and Medications." "Hot Water as a Topical Application," R. Ludlam; "Intra-uterine Medication," L. A. Phillips; "The Local Action of Iodoform, Iodine, Iodized Phenol, Tannin, Calendula, and Hydrastis," O. S. Runnels; "Topical *vs.* Internal Medication," J. C. Wood; "Dilatation as a Curative Measure," E. Blake; "Uterine Deviations," M. T. Runnels; "Electricity: its Application," B. F. Betts; "Postural Treatment," S. J. Donaldson; "Intra-uterine Stems," S. P. Hedges; "Pessaries: their Application," Philip Porter.

BUREAU OF PÆDOLOGY. C. D. Crank, Cincinnati, O., *Chairman*. B. F. Dake, Pittsburg, Penn., *Secretary*. B. Frank Betts, Philadelphia; P. E. Arcularius, New York; W. A. Edmonds, St. Louis; W. von Gottschalck, Providence; J. R. Kippax, Chicago; W. H. Bigler, Philadelphia; William Owens, Cincinnati; M. O. Terry, Utica, N. Y. Subject: "Skin Diseases of Infancy and Early Childhood."

The chairman of the Bureau of Anatomy, Physiology and Pathology, including Microscopy and Histology, Doctor J. C. Morgan, also announces that the above bureau will present for discussion the subject of "Malarial Pathology," and Doctor Philip Porter has been assigned "the consideration of the special relation, etc., of Malaria to Obstetrics and Gynæcology."

As Doctor Porter has but little sympathy with the hypothetical theory of "Malaria" in its relation to disease, he earnestly solicits any and all assistance from his brother practitioners they can possibly give on this bugbear question. Send us, please, any facts(?) bearing upon this subject, garnished by any theory you think you can sustain, and we will gladly incorporate it in our

report. As we humbly acknowledge, we haven't any personal information, based upon anything more tangible or definite than a very finespun idea that has been handed about from one section of the country to another, which has been labeled "Malaria."

"Yes, Madam" (to an anxious patient who has been waiting some time, for the Doctor's prescription to relieve her). "Yes, your system is thoroughly saturated with malaria and it will take some weeks to drive (?) it out." Suffering woman with a sigh. "Yes, doctor, I suppose so." Exit, wise Esculapius.

MECHANICAL TREATMENT OF RETROVERSION OF THE UTERUS.*

BY HENRY T. BYFORD, M. D., CHICAGO, ILL.

Retroversion of a fully developed uterus, in which there is no flexion, presupposes a displacement of the os and lower end of the cervix forward. Causes of retroversion act by either weakening the natural supports or bringing an abnormal or unusual strain to bear upon them. The mechanical treatment, or that which corrects the displacement while a cure is being accomplished, or attempted, should avoid weakening or interfering with the natural supports.

We may divide the more directly mechanical means usually adopted for correction of such deformity into four kinds.

1. Those which permanently fix the fundus in front of the pelvic axis.
2. Those which draw or fix the os or cervix back of the pelvic axis.
3. Those which place a barrier or obstacle to the forward displacement of the os and cervix.
4. A combination of two or more of these methods.

The fixation of the fundus forward has been done in four principal ways :

1. By the Alexander operation, in shortening the round ligaments. It was suggested by Alquié, recommended by Aran, experimented upon on the cadaver by W. A. Freund, and successfully performed and established as a therapeutic measure by W. Alexander.
2. The stitching of one (or both) round ligaments to the abdominal walls, as has been done by William H. Byford while performing laparotomy for another purpose. An examination after two

* Read before the Chicago Medical Society, July 6, 1886, and published in the *Journal of the American Medical Association*, Aug. 7, 1886.

menstrual periods had passed showed that the uterus was still held up by its new attachment.

3. Stitching a broad ligament to the abdominal wall, as has been successfully done by Kœberle and Schröder during laparotomy for another pathological condition. The uterus in Kœberle's case was found upon examination by Carl Braun, after ten years, to have retained its new position.

4. The stitching of the uterus to the abdominal wall, as recommended by Mueller and Lawson Tait, and performed by Skene, Keith, Heywood Smith and probably others by an especial laparotomy.*

These operations have the common disadvantage of an unnatural fixation of the fundus forwards.

Drawing or holding of the cervix back has been accomplished by the hazardous expedient of cauterizing the vagina for the purpose of producing cicatricial contraction behind the cervix, as by Amussat and others, or of causing adhesive inflammation in the posterior cervical and vaginal walls; or by the safer plan of denuding these apposed surfaces and stitching them together, as recommended by W. Löwenthal and performed by Hunter, of New York, O. E. Herrick, of Michigan, and others.

The objection to such procedure, besides the danger of peritonitis, lies in the fact that either the cervix must be held back rigidly or the posterior vaginal attachments must become loosened. Emmet thinks that the consequent traction upon the bladder must be a serious objection.

But the most common and available method is by pessaries of the Hodge class, such as the Albert Smith, Thomas, Emmet, Hewitt, Hanks, Nœggerath, Schröder, Gehrung, etc., which press backwards and upwards behind the cervix, and thus draw it back and drop the fundus forwards. They hang up the cervix, and thus supplement or supplant the posterior suspensory or sacro-uterine ligaments of the uterus. But in doing this they are apt to hold the uterus in a state of forced ante flexion, and weaken or irritate these ligaments; and by stretching the vagina longitudinally to loosen its attachments.

The pessaries with external supports such as Priestly's, Lazarewitsch's, Cutter's, Thomas', Scott's, can often be introduced by the patient, and thus sometimes serve a better purpose than those just mentioned. I have never used a pessary with more satisfaction than occasionally Scott's in case of relaxed vaginal outlet.

H. Marion Sims has recently† presented a retroversion stem pessary in which the cervix is pulled back by the intra-uterine

* The method of these operators, I have not for want of time and opportunity been able to determine.

† New York Obstetrical Society, April 6, 1886.

stem instead of a post-cervical bar. The bar of a Hodge pessary practically passes under the cervix and affords a hinge-like support to the stem. There are undoubtedly atrophic or imperfectly developed uteri with retroversion for which this instrument will be found preferable to others.

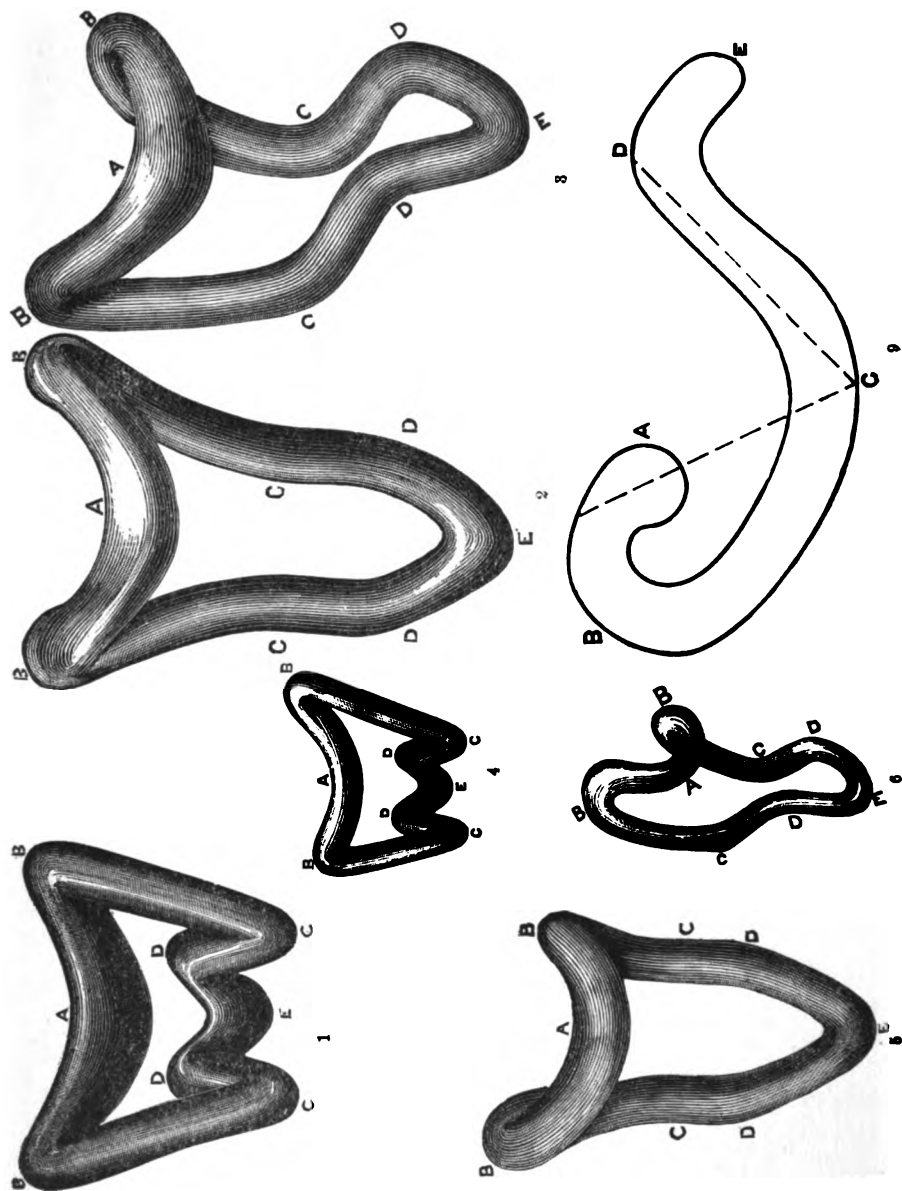
In some cases of small vagina and cervix, the elastic ring of Peaslee, Mayer, or Dumont-Pallier, or an inflated rubber bag or ring, or a hard rubber round or oval ring, may be made to distend the vagina and thus draw the cervix into a less abnormal position. But the majority of them are relics that belong more to history than to practice, which we take out oftener than we introduce, yet which occasionally do some good where others cannot be used. They remind us that no form of pessary can be used for all cases and reproach us for having no suitable pessary for many cases.

The method of keeping the cervix and os back by placing an obstacle in front of it, acts upon a rational principle, and does not labor under the disadvantage of supplanting natural supports, and thus favoring their atrophy, irritating or pressing upon tender and inflamed tissues behind the cervix, of greatly stretching the vagina, of drawing open lateral lacerations of the cervix, or of holding the uterus in a state of harmful immobility. This may be accomplished by a pessary or by a plastic operation.

Pessaries of this class should keep the cervix so far back that the abdominal pressure will force the fundus forward or, in case the ligaments are utterly relaxed and useless, should hold the cervix so near the hollow of the sacrum that the fundus will, for want of space, be unable to fall back into permanent state of retroversion. The simplest and least objectionable form is the cotton plug, which is made into a shape resembling a small spool of thread, saturated with glycerine or some other disinfected lubricant, placed transversely in front of the retroposed cervix, and changed every day. After a time the patient may take the plug out at night and have it introduced in the morning. Some patients learn to use them themselves.

A rectal tampon which was recommended by Huguier in 1865, might be made to act efficiently in this way in exceptional cases in which nothing can be retained or tolerated in the vagina, especially if the weakened perineal body were supported at the same time by a perineal pad. A flattened globe of glass, hard rubber or hollow metal of appropriate size, might for want of something better be occasionally used by the patient with comparative comfort and benefit.

Courty's pessary consists of two bars which rest on the pelvic floor, and are joined by a cross bar in front where they rest against the pubes or vaginal entrance. Behind, the bars curve up



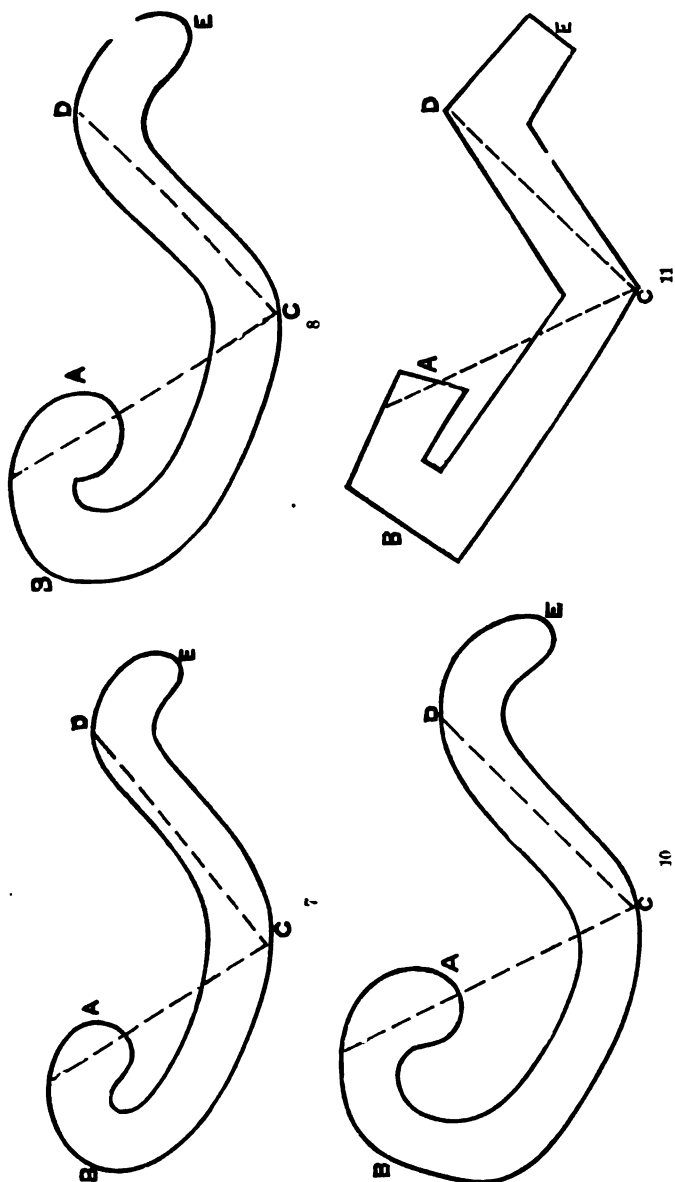
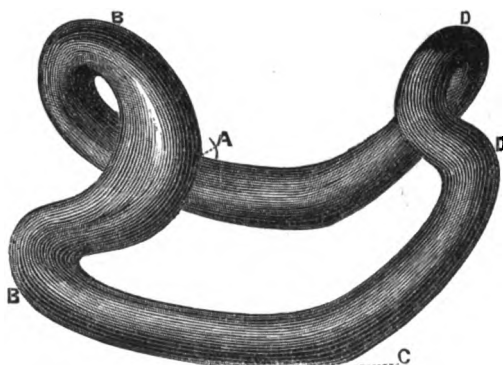


PLATE 1.—a, neck; b, shoulder; c, elbow; d, handle; e, free end; 1, 2, 3, different views of same instrument; 4, 5, 6, modified for lateral displacement; 7, for small vagina (profile); 8 ordinary form; 9, for lax vagina and outlet; 10, for raising heavy uterus from relaxed pelvic form; 11, schematic.

in front of the cervix, and form a more or less rigid barrier to its forward movement.

Gehring's* instrument has the shape of a very small excessively curved Albert Smith pessary, with the cross bar in front of the cervix. The chief objections to it are that the pressure against the cervix must be constant, and hence, unbearable, to keep either it or the uterus in place, and that the vaginal walls are apt to be held apart.

I have constructed a pessary to take the place of the cotton plugs I formerly used, which I think possesses the virtues of



SUPPLEMENT TO PLATE I.

Handle curved up behind symphysis instead of under the pubic arch. For relaxed vaginal outlet.

both Courty's and Gehring's, although it was devised and so far perfected before I had seen or studied either of them. It may almost be made from a Thomas' or Albert Smith shape by bending forward the posterior arms so as to form a sort of crescent running around in front of the cervix and impinging against its anterior and lateral vaginal junction.

The uterus settles in this crescent or neck more comfortably than against a cotton plug, and if too heavy for its supports, is held up by the pressure upwards of the neck, or crescent against the vagina around the anterior half of the cervix. The shorter curve of the arms is placed anteriorly instead of posteriorly as in the Hodge patterns, in order to retain the lever action. (Plate I.)

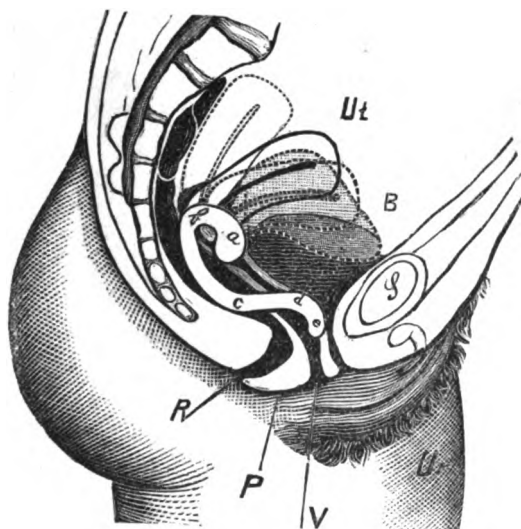
The parts of the instrument are a neck *a*, two shoulders *b, b*, two elbows *c, c*, two arms *b, c, d*, a handle *d, d*, and the tongue, or, free end, *e*. The uterus impinging against its neck at *a* makes a lever of it, whose arms are represented by lines passing from *a* to *c* and *c* to *d*, and which, during ordinary abdominal pressure forces the handle *d, d* up behind the symphysis pubis instead of through the vulva. The elbows or fulcrum *c, c*, rest on the poste-

*The *anterversion* pessary, called "Gehring's pessary," is not the one referred to.

rior wall of the vagina or on the pelvic floor, at either side of the rectum. The longer the arm of the lever *a c* in comparison with *cd* the greater the pressure of the handles and the less their liability to escape externally. If during heavy lifting, defæcation, or abdominal pressure while in a stooping position, the depressed anterior vaginal wall forces the handle down until it appears under the pubes, the patient has only to push it back; or if (as seldom happens with a properly adjusted pessary) it does not slip into proper place, she has but to assume the knee chest position. This descent of the handle under great pressure, instead of being a disadvantage acts as a sort of safety valve, to prevent injury being done.

On account of slight relaxation of the vagina or of the pelvic floor, it may, when the uterus is unusually heavy, become necessary to change the first instrument for a larger size, or else make

some alterations. Later a smaller one may again be used. The alterations most often required are raising or depressing of one or both shoulders, or of the neck, or of both shoulders and neck, in order to afford more or less general support at different points; or to vary the curves of the arms in order to increase or diminish the lever power. Escape may be effectually prevented by taking off the tongue, making it more like a Courty or like a reversed



PESSARY IN PLACE.

PLATE 2.—Dotted and interrupted lines show possible temporary positions of the uterus allowed by the pessary.

Explanation Plates 2 and 4.—R, rectum; P, perineal body; Ut, urethra; V, vaginal entrance; S, symphysis; B, bladder; a, b, c, d, e, pessary; Ut, uterus; L, lines indicating places for uniting cervix or anterior vaginal walls with posterior vaginal walls.

sleigh pessary. It may then be used for retroflexion and prolapse.

A very small instrument with gentle curves is required for the virgin and congenitally sterile woman, while a very large one with abrupt anterior curves and broad handle may be required for the child-bearing woman with relaxed vagina and pelvic floor. The shoulders must also be higher in proportion to the centre of the

neck when the upper vagina is relaxed, so that they may get a vaginal bearing on either side of the cervix. (Plate 2.)

I have made the pessary fulfil, in its own class of cases, the following six requirements :

1. To place the uterus in a normal, or nearly normal, position.

2. Not to interfere with the natural supports.

3. To support the uterus in a natural manner ; *i.e.*, to afford an elastic or yielding support.

4. Not to interfere with the use

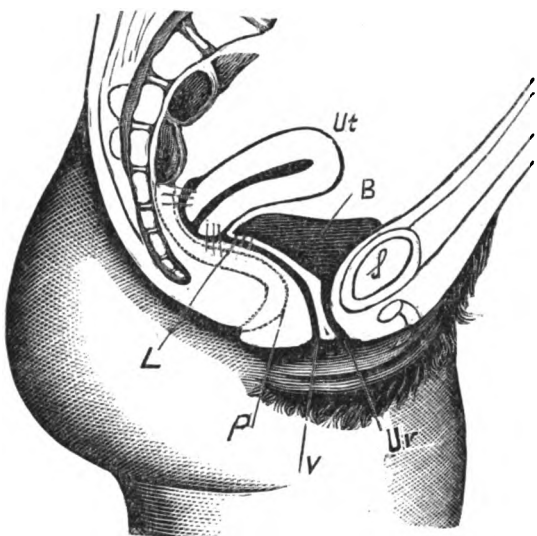


PLATE 4.—Median section after operation for raising posterior vaginal wall, perineum and pelvic floor, as a barrier to the forward displacement of the cervix. The section is supposed to swerve to one side of the rectum, *i.e.*, to give a better view of the relations of the pelvic floor to the uterus. Rectum indicated by dotted lines. Places for uniting vaginal or cervical and vaginal walls indicated by lines.

of a speculum.

5. Not to interfere with the marital relations.

6. The patient shall be able to both introduce and remove it.

The ordinary Hodge pessary and its modifications are generally faulty in requirements one, two and six. This pessary allows the vagina to collapse, and practically presses against no supports, except the posterior vaginal wall or pelvic floor. Its neck is firmly pressed upon by the cervix uteri only a part of the time, *viz.*, during the action of influences tending to retrovert the uterus ; the constant pressure is distributed half-way around the cervix

and is against the vaginal junction. All other instruments of this class fail because they exert constant pressure on the cervix in front and are thus unscientific and intolerable. But perhaps its most valuable characteristic is that it can be properly introduced by the patient. She has but to slip first one of its shoulders under the symphysis, and then the other over and beyond the depressed fourchette, turn it so that the neck will be toward the urethra, and then assume the knee chest position and allow it to slide into place, or she can introduce it while on her side after having replaced the uterus by the knee chest position. In removing it she turns it a little more than a quarter circle, so that one shoulder is toward the symphysis, and then, as she pulls it out, pries either the upper or lower shoulder out under the symphysis, or over the fourchette, as she finds easier. A slight twist or rotary motion as the first shoulder escapes, so as to miss the urethra, will enable her, after a few trials, to remove it easily and painlessly. After wearing it steadily for a couple of months she may remove it nights and introduce it mornings for three, four or six months longer, avoiding sleeping on her back. A very practical point here is to caution the patient after removing it not to allow the bladder to become much distended in the night until all tendency to retroversion has been lost. She may either avoid taking fluids in the evening, or else get up and urinate during the night. Carelessness on this point in the treatment of retroversions often delays, and sometimes prevents, a cure.

The pessary may usually be introduced by the physician, in the lithotomy position by following it into the vagina with the finger under the handle, and pressing down, or back, the cervix while the other hand pushes the instrument and uterus into place, or if successful by putting her into the knee chest position, and displacing the fundus from the hollow of the sacrum by the finger, when the instrument need only be allowed to follow into place.

Especial contra-indications to this form of pessary are : Tenderness or induration in the vesico-cervical region, decided *retroflexion*, and insufficient projection of the cervix into the vagina, and an unusually short vagina, more particularly the anterior wall. Irritation on either side of the urethra or pressure upon the deep dorsalis clitoridis nerves and vessels are not contra-indications, but call for a greater approximation, separation or downward curving of the arms anteriorly at the handle. All pessaries require some skill in preventing irritations.

Especial indications are : Retroversion with subinvolution after abortion or labor, or with bilateral laceration of the cervix in which the traction of the other forms act hurtfully, a lax vagina, post cervical tenderness. It is useful after the uterus has been held anteverted by the Hodge instruments for some time and we

wish a less rigid support, and one that the patient can use, and gradually lay aside. I find the uterus less apt to retrovert after its prolonged use than after any of the Hodge class.

In preparing a subinvolted uterus with bilateral laceration and eversion, but without retroversion, it is also exceedingly useful in lifting the cervix from the pelvic floor. When properly adjusted it acts as a support to the everted labia as well as to the uterus, and often causes the ulceration to quickly fade out. One shoulder may be enlarged or raised for lateral flexion or inclination, provided no rigid ligaments or adhesions interfere.

As pessaries whose only aim is to relieve retroversion temporarily, the Hodge forms will perhaps answer in more cases, for they hold the uterus anteverted, but as a pessary which interferes the least in most cases for which it answers, and which is suited to its own class better than any other, I find this one of great value.

I hope that it will not be tried by any one for all cases of retroversion, and condemned because of frequent failures. For instance, I have a case of retroversion and antelexion with a long and flabby anterior vaginal wall, in which I failed with this pessary, because the cervix slipped down under the neck if the neck was high, or slipped over it if it was too low. Yet in this case a thicker neck would undoubtedly have remedied the defect. The Albert Smith pessary had been tried twice before, and was not tolerated. The most common of the contra-indications which I have met are the retroflexions which so often co-exist with retroversions. For these cases the bar should be behind the uterus or the Harry Sims form, be used, or my pessary without the tongue.

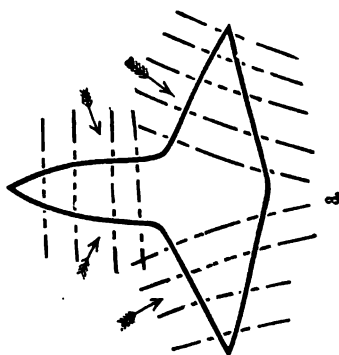
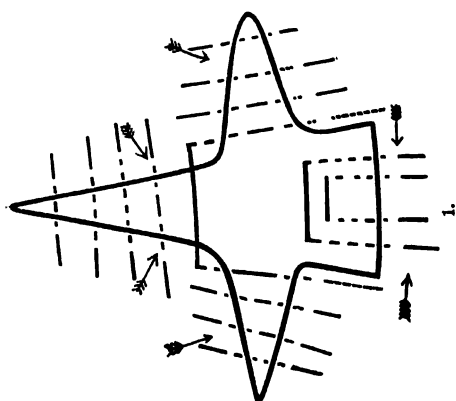
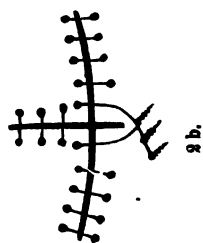
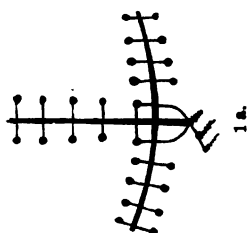
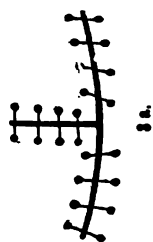
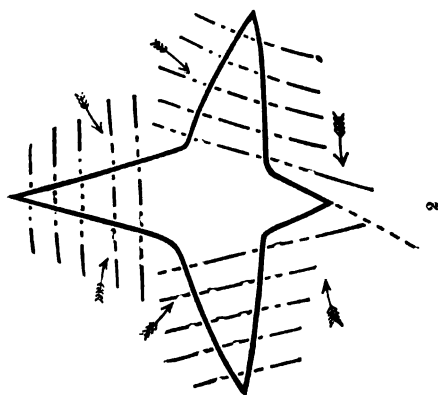
Among plastic operations I have found the raising up of the recto-vaginal promontory and perineum of great benefit, and sometimes curative. This makes it necessary for the womb to rise in the pelvis before the os can get forward, and thus places a barrier before the cervix, and also tends, by fixing the vaginal walls, to correct its excessive mobility. It is chiefly accomplished by shortening the relaxed or retracted fibres of the levator ani muscles, and including some of the connective tissue with the stitches. The form of denudation must vary with each case. That which I have found most successful is a transverse strip removed just inside of the fourchette or carunculæ, between one and two inches long, and from one quarter to an inch wide, crossed by a triangle whose base is at the posterior commissure, or, if that had been destroyed at the junction of skin and mucous membrane or cicatricial surface externally, whose sides pass through or include the lower carunculæ, and whose apex is in the median line of the posterior vaginal wall beyond the introitus (Plate 3). An imper-

fect star is thus produced which contains considerable denuded surface, but whose points or angles, upon being sewed up, will unite ends of muscular fibers without much traction upon other surrounding tissues or displacement of parts. The main stitch, introduced through the right labium majus at the base of the triangle and brought out through the mucous membrane at a point near where the same side of the triangle intersects the posterior border of the transverse denuded strip on the left side, and brought out through the left labium at the base of the triangle, will draw the star together in the form of a cross, and indicate what edges are to be stitched together. This main stitch should not be twisted until after the vaginal stitches.

The triangle will, of course, be divided in the centre as the star is pulled together, forming two long right-angled triangles whose shorter legs form the retorted cutaneous raphe of the perineum as they meet in the median line. Their hypothenuses coming together in the median line, in the vagina form one side of the cross; the united transverse strip forms the other side. When the patient has not borne children the perineum is seldom greatly relaxed externally and the vulval wedge may be omitted, so that the base of the triangle will be upon the posterior border of the transverse denudation. A small neck or minute triangle may be taken from the fourchette, whose apex is at the posterior commissure, and whose base is at the anterior edge of the transverse strip, to better raise the sagging fourchette. Or if the fourchette be already high, the point at either end of the transverse strip may be placed so that when the triangle projecting into the vagina is closed both sides of the transverse strip will be of equal length and be easily united. Broad strips must, of course, not be taken from the vagina of those who may afterward bear children; but, on the other hand, the triangle should be made broad and long and the transverse strip wide in operating upon those with rectocele or who have passed the menopause, in whom there is often great relaxation, destruction or retraction of tissue.

When the *levator ani* has been torn laterally, or when the fibres which pass under and behind the rectum have become relaxed, it will be better, instead of removing the apex of the triangle in the median line, to remove a strip on either side of the rectum, something like those removed in Freund's operation, and thus draw up deeper fibres of the *levator ani*. They may be removed and sewed up immediately, *i. e.*, before the rest of the figure, as Martin does in his "*Elytrorrhaphia duplex lateralis*," and may go with all the varieties of the anterior denudations mentioned.

Since becoming accustomed to these forms of denudation I have found it also more convenient to denude the apex of the



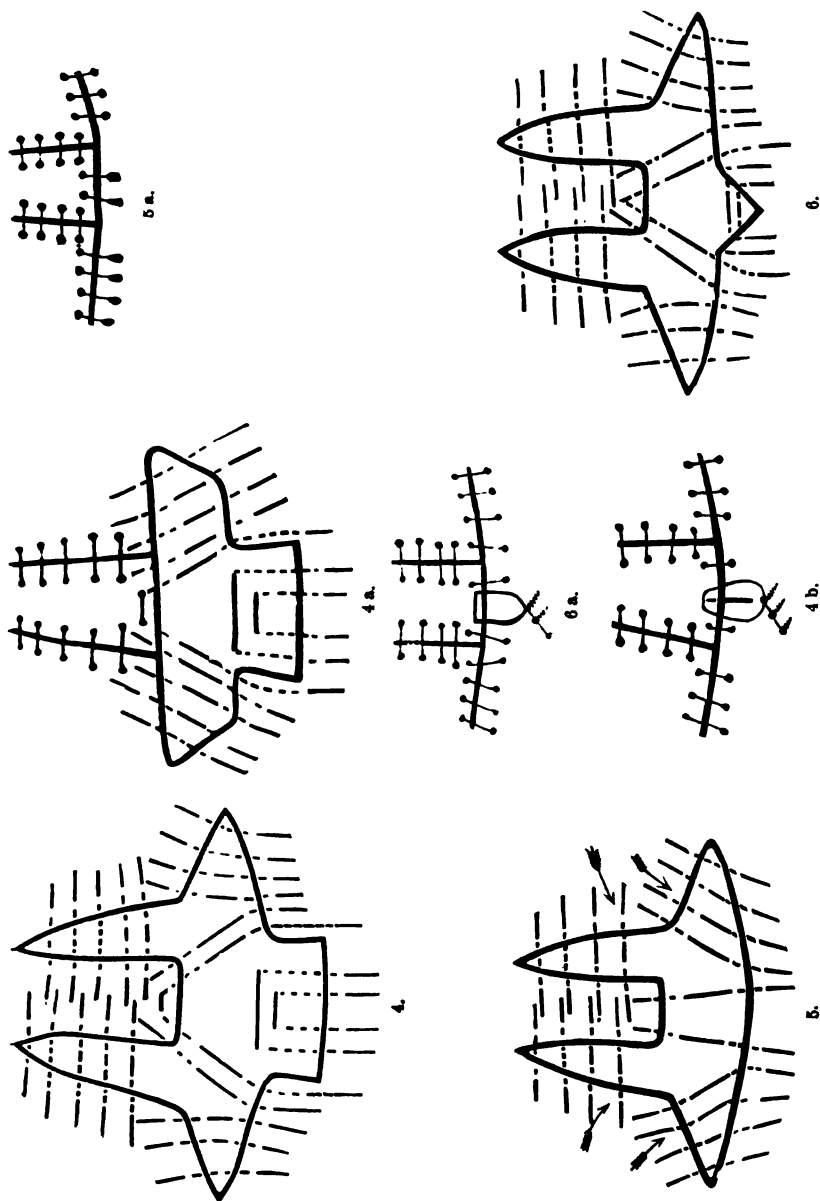


PLATE 3.—1. Complete figure, with central triangle. 1 a. United. 2 With small triangle in vulva, for raising fourchette. 2 a. United. 3. Without narrowing vulva. 3 a. United. 4. Complete figure, with lateral strips united. 4 a. Posterior strips united. 4 b. United. 5. Without narrowing the vulva. 5 a. United. 6. Triangular notch for raising the fourchette, added. 6 a. United. Arrows show the main directions of muscular fibres. Dotted lines show where the stitches dip into the tissues.

triangle first and sew it up before denuding the rest of the figure, thus saving the loss of considerable blood. The objection to this consists in the difficulty in knowing, in the beginning, how far up the vagina to carry the denudation.

The transverse denudation is for shortening or reattaching the fibres of the levator ani which pass from the pubic rami forward to the perineal body and lift that body, while the antero-posterior denudations shorten or raise those that pass more directly toward the median line under the vagina and rectum, and thus lift the pelvic floor and posterior vaginal wall (Plate 4). We thus produce the greatest possible effect in raising and strengthening the parts with the least possible loss of tissue. The uniting of separated fascia and fixation of the vagina to its connective tissue is attained at the same time that the muscles are shortened. The transverse strip not only raises the perineum but attaches it to the pelvic floor, on either side of the rectum. The stitches must be passed deep into the sides or edges of the denuded figures, but should not include their middle sections, since that would bind down instead of raising up the parts. When the parts have been previously injured, and are traversed by cicatrices, the form of denudation must, of course, be modified to suit the case, viz: to remove the cicatrices and restore the injured tissues to their natural relations. The operation should be suited to a particular case. The old notions of building a pyramid which never existed; of constructing a firm triangle in the median line, where a firm triangle must be a pathological condition; of projecting a huge rigid cicatrix between the elastic walls of the rectum and vagina, to run the risk of being gradually melted away by time and traction; or of cutting away, instead of replacing, prolapsed masses, are the crude methods of an age of transition, and continue to live, as useful remedies, only for want of something better.

If the anterior wall of the vagina be much loosened anterior elytrorrhaphy should also be performed as an important, if not necessary, part of the cure.

The patient, after all plastic operations for retroversion, should be kept in bed, but not be allowed to lie on the back for two weeks. It goes without saying that should such plastic operations be undertaken indiscriminately, failure must be the result. The main part of the cure must be made before this nearly mechanical part, viz: the restoration of natural checks upon the motions, and hindrances to the falling over backwards, of the womb.

To the criticism that I am producing an unnatural state of things by thus elevating the perineum and recto-vaginal promontory, I must answer that I have seen many well developed patients in whom the promontory and portions of the perineum were naturally thus elevated without inconvenience either before or after

marriage, and that I am imitating nature by taking the perinea of such women as models for the operation.

The anterior vaginal or cervical walls may be stitched to the posterior vaginal walls, as a preliminary or first step in performing the above described operation, if the case be unusually unpromising or complicated, and the patient be beyond childbearing.

The denudations should be made where the walls come together after the uterus has been anteverted and the cervix pushed well back, and need not be as extensive as in the Le Fort operation for prolapse. Occlusion of the vaginal canal must, of course, be avoided.

This brings us to the combination methods. The Alexander operation is nearly always combined with support by a pessary for a few weeks or months. It should often be preceded by a plastic operation either for raising or restoring the perineum and recto-vaginal promontory. Other combinations may be devised, some fanciful and some practical. The posterior cervical and vaginal surfaces may be united and a Harry Sims or Gehrung pessary be used to hold the uterus in place until the union is firm and the tendency to retroversion diminished. The abdominal section operations may be supplemented by plastic operations or pessaries. Both walls of the cervix may be stitched to the posterior vaginal wall, before and behind, or the cervix may be stitched posteriorly and laterally to the vagina.

The Fitch, Studley, Schultze's figure eight, and sleigh pessaries, the Hurd, Fowler, Fritsch and Woodward patterns, Martin's eccentric ring, cotton plugs used as recommended by Thomas, etc., are more or less perfect examples of combined traction behind and support in front. They are indicated when the upper surroundings and supports of the uterus are tender, and motion of the organ is to be limited by a firm hold upon the cervix.

In conclusion it must be said that such mechanical treatment as a routine and sole remedy for retroversion is only exceptionally curative, since the original cause and its accompanying or resulting pathological conditions, if still present, tend to break down all barriers and tear loose all attachments.

ABSTRACTS.

—CLINICAL CONTRIBUTIONS TO OBSTETRICS AND GYNÆCOLOGY.

—*Management of Natural Labor.*—Normal labor being a natural physiological process in its management, few and simple are the duties that ordinarily devolve upon the accoucheur and interference on his part is seldom necessary. It is his office to superin-

tend and direct, to foresee dangers, to prevent accidents, and promptly meet emergencies.

In the ability to render aid and assistance when needed to women in this the most trying physical ordeal of their lives consists the dignity and beneficence of the profession of the obstetrician. This it is that raises it far above the vulgar calling of the midwife, makes it worthy of the attention and pursuit of intelligent men, and constitutes it an important element in civilized society.

Patience, a virtue which seems to have no place in this restless, bustling age, is one of the first and most essential qualifications of the obstetrician. Truly there is no wiser maxim in practical medicine to-day than that of the learned Dr. Blundell, of London, "meddlesome midwifery is bad." Such is the great conservatism, the wonderful mechanism, and the beautiful adaptation of means to ends in nature that often results are accomplished by her unaided powers that at first sight appear to be impossible, and rash and untimely interference is always attended with danger and frequently with fearful disaster. Far be it from us to counsel one moment's delay, when for the sake of either mother or infant action is demanded, but it is our purpose here to point out what in our experience are the indications for and the best ways of giving assistance when during labor it is required.

The first stage of labor in many instances may be long protracted, lasting for a number of hours or even days without any harm resulting to either mother or infant. We have often seen cases, as has every other practitioner of obstetrics, wherein labor has commenced and the uterine contractions progressed vigorously until from some emotional or other cause the pains have stopped and all action for a time completely suspended.* This condition of rest or inertia occurring at this time does not, as in the second stage, call for treatment, because it is salutary in its effect, enabling the system to recuperate its powers and better fitting it for effort during the period of expulsion. Atony or exhaustion of the uterus is, however, an entirely different matter from inertia, and when present or threatened during labor urgently demands the most prompt attention of the medical attendant. When, therefore, the first stage of labor lasts beyond physiological limits assistance is certainly required to finish the delivery, for

* A remarkable case of this kind, showing the powerful controlling influence of strong mental emotions upon the progress of labor, occurred in the practice of the late Dr. Milton Antony. He was once called to attend a patient in the first stage of labor and found the membranes protruding, the os dilating and every thing promising a quick and easy delivery, when the woman's husband came home beastly drunk, and her distress and mortification at this so affected the action of the uterus that the labor was entirely arrested and continued so until the debauch ended, a period of a week or ten days.

after long-continued, ineffectual exertion the uterine muscle, like every other muscle of the body, falls first into a state of tonic or tetanic contraction, and then becomes relaxed and paralyzed, the first condition may cause rupture of the womb or asphyxia of the child from obstruction of the placental circulation, and the other predisposes to *post partum* hæmorrhage. Again other serious and hurtful consequences may follow abnormal duration of the first stage, such as congestion or inflammation of the cervix and lower portion of the body of the uterus from the constant pressure of the head against these parts, or the woman's strength may break down from the persistence and severity of the pains preventing rest and sleep, and she be unable to make the necessary muscular effort in the second stage or resist the dangers of the puerperal period.

The proper treatment of delay in the first stage of labor varies with different cases, as it is of course depends upon the causes that give rise to the difficulty.

Artificial Rupture of the Membranes.—Certain of the older obstetric authorities held that no harm could result so long as the amniotic sack continued intact, and that its artificial rupture was never necessary, no matter how long it remained unbroken. Cases often occur, however, in which the labor has been retarded many hours and the woman brought almost into a state of exhaustion, because from excessive toughness of the membranes or the existence of hydramnion the advance of the head is obstructed and efficient uterine contractions prevented. Such cases usually terminate rapidly and satisfactorily when the amniotic fluid is let off by the accoucheur. The best time for rupturing the bag of waters is when the os is dilated or dilatable and the head can be felt through the somewhat flaccid membranes; it should be done as the pain is passing off; for then the presenting part of the child is forced down into the cervix and thus prolapse of the cord is prevented.

The Use of Chloroform.—The inhalation of chloroform during the first stage of labor increases the action of the womb by blunting the sensitive spinal centers, and thus abolishing their inhibitory influence. It should be employed, however, with care and caution, and never carried to the extent of complete anæsthæsia, for this so relaxes and weakens the uterus as to give rise to serious complications during the second and third stages.

The Use of Ergot.—Powerful oxytocics such as ergot, cotton root, etc., are never to be employed during the first stage of labor, except as auxiliaries to instrumental or other operative procedures. The use of this drug has practically been discontinued by European obstetricians.

Artificial Dilatation of the Os Uteri.—In cases in which the membranes have ruptured before the commencement of, or early

in the course of labor, and the liquor amnii has long drained off or in those in which the os, owing to either spastic or organic rigidity or to deficient uterine action, does not open artificial dilatation is of great benefit in two ways, viz.: First, by mechanically stretching the parts and thus making room for the passage of the child, and second, by reflex action stimulating the uterus to more perfect contraction. The finger for obvious reasons is in the majority of instances the best instrument to accomplish this purpose. Digital manipulation to produce dilatation of the os uteri must, however, only be attempted when the cervix is dilatable, that is when it is soft, relaxed and yielding, and should always be done between or during the subsidence of the pains, for the reason that the contractions of the womb begin at the cervix and pass in a wave upward to the fundus, and the os is firmer and smaller at the commencement of a pain, and expands as it is going off, endeavors to effect dilatation at the beginning of a contraction, therefore only adds to the suffering with no other than the bad result of tearing or bruising the muscular tissue. When the amniotic sack is present in practicing digital dilatation, care should be taken to avoid its rupture as long as possible, because we are aided much more in our efforts by the elastic bag of waters than by the hard head of the child, and the premature loss of the amniotic fluid gives rise to all those trying complications comprehended under the term "dry labor" and is especially liable to cause faulty presentations or occipito posterior positions of the vertex. In these cases the finger should be passed high up separating, without breaking the membranes from the wall of the uterus.

When the cervix is undilatable the hydrostatic dilators of Dr. Barnes, of London, are a most valuable resource; they closely imitate the natural process and overcome the resistance of the parts by keeping up a firm, equitable, constant pressure. It is to be regretted that these bags can not be constructed of some material that would be more indestructible and that could better stand the wear and tear of practice, for as now made, when once or twice used, they are ruined forever, and if kept without use the India rubber undergoes some chemical change that makes it worthless. Often when required to meet some sudden emergency these bags will be found rotten and bursted and totally unfit for service.

For their physiological effect the use of belladonna ointment, atropia and the hot douche against the cervix as a means of promoting relaxation, has proven in our hands of little or no value.

The presence of cicatricial tissue or malignant diseases causing stenosis or occlusion of the os sometimes makes the use of the knife necessary. A remarkable case of this kind occurred in our practice, and is reported in the transactions of the American Gynæcological Society for 1880. The occlusion in this case was

complete and was due to adhesive inflammation following the application of the cyanide of mercury to the cervix during pregnancy for the cure of obstinate ulceration; the operation of vaginal hysterotomy had to be performed before delivery could be accomplished. Obliquity of the uterus and malpositions of its neck may sometimes be mistaken for occlusion; examination in these cases usually shows the head low in the pelvis covered by the stretched anterior wall of the womb and the os closed and turned high up against the promontory of the sacrum; dilatation is readily effected by changing the position of the woman, the adjustment of an abdominal bandage and by means of the finger, drawing down the cervix into the axis of the superior strait so that the pressure of the amniotic sack and the presenting part can bear properly upon it. The knife ought to be employed in stenosis and occlusion, only after all other means have failed to effect dilatation and never in cases of simple rigidity, because its use is very apt to be followed by acute inflammation and the incisions made offer a ready way for the entrance of septic matters into the blood.

The Use of the Forceps.—In 1863, Dr. Isaac E Taylor first suggested and practiced the early use of the forceps in the first stage of natural labor. This was then a decided innovation in practice and totally at variance with all recognized obstetric authority and has not as yet received the full assent and acceptance of the profession. As we have had occasion many times to resort to this operation, and have seen its great value in certain cases, we desire here to give the results of our experience and to add our testimony to that of others as to its practicability, safety and life-saving usefulness.

During the first stage of labor neither traction, compression nor leverage is to be made by the forceps in the same manner as when these instruments are applied in the second stage. They are to be employed, not to forcibly or rapidly pull the head through the cervix, but simply to hold it properly in contact with the internal os during a pain, and thus aid the natural powers in effecting dilatation. When used in this way the forceps promote flexion, and by their presence within the uterus excite more regular and perfect contraction of that organ. This reflex or so-called dynamic action is best exerted when the patient is not in a state of anæsthesia, and hence, whenever possible, these instruments should be applied without chloroform during the first stage of labor. There is no especial danger in the introduction of the forceps into the interior of the womb, nor is the risk proportionate to the size of the os at the time of the operation, for often when used in the second stage the blades have to be passed high up within the uterine cavity without any attendant bad results, and clinical expe-

rience has shown that by their proper use no more harm is done in the first stage through an undilated os than in the second stage through a contracted vulval orifice. Dr. Taylor* has proved both by examination of many living patients, and by close study of *post-mortem* specimens that lacerations of the cervix in such cases very seldom occur, and Dr. George Johnson,† from statistics of one hundred and sixty-nine cases under his charge in the Rotunda Lying-in Hospital of Dublin, in which the forceps were applied before the os uteri was fully open, says "the practice is not alone safe and justifiable, but also a great preservative of the lives of both mothers and children."

It is to be fully understood that it is the *early* and not the *frequent* use of the forceps during the first stage of labor that is advised and advocated, for cases are not often met with in which a resort to this procedure is proper or necessary. In the Report of the Rotunda Hospital for 1876, Dr. Johnson very truly says on this subject: "This practice should never be adopted merely in order to save our own time, nor should it be attempted when the os uteri is rigid; in such cases the proper means should be taken to overcome this state, and it should alone be had recourse to when the life of the mother or that of her offspring is in jeopardy." This correctly expresses what the indications are for the use of the forceps in the first stage of natural labor, and it is an ignorance or misunderstanding of these, and a failure to appreciate its true scope, and the ends to be attained by it that has led to the untimely and improper performance of this operation, and to all the evils resulting therefrom; and it is this abuse that has caused the great opposition to it on the part of many distinguished obstetricians.

—ASEPSIS, NOT ANTISEPSIS: A PLEA FOR PRINCIPLES, NOT PARAPHERNALIA, IN LAPAROTOMY.—*Obstetrical Society of Philadelphia*.—Medicine, like other branches of science, has been most retarded in its growth by the accumulation of all sorts of useless details. Some of these incrustations still clog the advance of abdominal surgery, and will be given up with a notable diminution in the general percentage of mortality. I refer to the use of carbolic acid and mercuric solutions at the operating-table, and to the continued use of any elaborate abdominal dressing.

The use of antiseptics in the patient's belly is full of dangers and inconsistencies, for the following reasons:

* The Early Use of the Forceps in the First Stage of Natural Labor. By Isaac E. Taylor, M. D.

† *Obstetric Journal of Great Britain and Ireland*, March, 1879.

First : If used in strength sufficient to certainly prevent sepsis, the patient is very often killed along with the germs. I have myself seen death from carbolic-acid poisoning. The *American Practitioner*, November, 1881, p. 260, quoted by Dr. Goodell : "The first four cases done in the theater at the beginning of last session had hæmorrhage from the kidneys, and two of them died. I never had any thing like that before. It was purely carbolic-acid poisoning ; of that I have no doubt whatever." Thomas Keith speaks of several cases in his own practice, and references might be indefinitely multiplied. Regarding the use of the bichloride solution, it is sufficient to say that its use has been very much curtailed in all maternity hospitals, even as a vaginal wash. The danger-line is here a very broad one, for the limit appears only to depend upon the most variable of all factors, the individual susceptibility.

Secondly : It is the great tendency of all operators, and in particular their assistants, to forget the principle involved and pin their faith to the accidental means of establishing it. This can be seen abundantly illustrated in almost any hospital in the land, where a clean napkin worked in and around the joints and grooves of the instruments in use, or carried under the nails of the operator's fingers, will exhibit sad evidences of soil. Then, too, the actual conduct of the operator is often modified by the false sense of security begotten by the incomplete use of antisepsis. I saw this well illustrated by a surgeon of more than local repute. The case was a herniotomy in which a large femoral sac was opened. The spray was throwing out a dense cloud, instruments and sponges were immersed in a two-per-cent. solution of carbolic acid, and elaborate dressings were ready. A coil of intestine protruded from the wound for several inches, and it lay first on the old hospital-blanket below, and then, in the effort to reach the ring, was turned upon the night-gown above. The antisepsis was here made a farce by these and other glaring inconsistencies.

If germicides must be used at all, let it be before the operation, and in strength sufficient to neutralize any sepsis about instruments, sponges, etc. Then let the operator go to work with clean instruments, clean sponges, and clean hands, and he will need no antiseptic, and the patient's belly will no longer be a battle-field where germs and solutions fight, often with such direful results to the host. It is my belief that it will not be long before the day of solutions will be past, and that in the future the successful surgeon will go to his work with pure water or dry pans for his instruments and fluid enough to cleanse sponges. My own practice has been to use hydrant-water boiled for an hour and allowed to stand, or, better still, distilled water, as used by Professor Schroeder, and independently suggested and used by my friend Dr. Joseph Price. I do not believe that reservoir-water, dirty as it often is, ever con-

tains any of the specific matter productive of septicæmia ; but the process of boiling and using only the supernatant liquid makes it perfectly harmless.

Another fallacy discarded by some of the greatest operators, but perpetuated by many, is the transference of the use of the elaborate Listerian dressings of general surgery to the abdominal wound. These dressings, so manifold and multiform, are clearly intended to prevent sepsis from penetrating the now closed abdominal wound. This is an accident which fortunately never occurs in the intra-peritoneal method, the rapid agglutination of peritoneal surfaces effectively closing the sac. A sterile, dry powder will absorb the slight serous discharge at the edge of the wound and suture-exits, and above this some absorbent cotton and a firm bandage is all that is required.

While the danger of infection of the peritoneum through the closed wound is minimal, that of an infection of the belly-wall through stitch-holes is very great ; and this is best prevented by the dressing recommended by Keith, of carbolic acid and glycerin, one to eight parts.

With the mind thus freed from the notion that these solutions and dressings are accomplishing any thing,—from two such dangerous fallacies,—operators at large will work with a living consciousness of the real conditions of success, and they will then be on the alert from the beginning of the operation to its close, keeping within the mental horizon an exact knowledge of every thing coming into contact with the patient's belly.

The expression of my convictions and practice will be of value in so far as they are in accord with the following letters upon the subject by the two greatest abdominal surgeons in the world, Lawson Tait and Thomas Keith.

Lawson Tait, in a letter dated March 15, 1886, to the writer, says, "I still use tap-water and nothing else : it is never boiled. My instruments are prepared by being washed in soap and water merely. I use no elaborate dressings for the wound, never using any thing at all except absorbent cotton-wool.

"Yours very truly,

LAWSON TAIT."

From a communication from Thomas Keith, of Edinburgh, written March 16, 1886, I make the following extract : "The secret in abdominal surgery, the secret in all surgery, consists in carrying out the antiseptic principle. You may do this in a simple way or you may do it in a complicated way. All instruments, needles, forceps, sponges, etc., every thing about the wound, must be disinfected. A weak carbolic solution applied to the wound can do no good—nor harm. You may safely use hot water. My instruments, after an operation, are scrubbed with a nail-brush, especially the forceps-points. This is repeated before the next operation with a

five-per-cent. solution of carbolic acid. The greatest risk is that we put in septic matter on our hands, instruments, and sponges. Sepsis may come from the wound, but it rarely ever penetrates inside. I use a simple dressing of gauze, eight or ten folds soaked in one to eight carbolic acid and glycerin, extending two or three inches or so beyond the line of incision on all sides. Over this some ordinary cotton-wall, a flannel bandage, and nothing else. Use this, and you will never use any thing else. And don't look at it for a week or ten days. You ought, for the patient's comfort, to put on an antiseptic dressing of some kind. You will probably often have suppuration with stitches if you do not.

"Yours sincerely,

"THOMAS KEITH."

—**DIFFERENTIAL DIAGNOSIS OF SARCOMA AND CARCINOMA IN THE BREAST.**—Not to neglect surgical subjects, let us give the above, which will be a résumé of a clinical lecture given last week at the Hôtel-Dieu by the eloquent Dr. Tillaux, who presents the points in a graphic manner: "We are going to operate to-day upon a woman, 56 years of age, who is afflicted with a tumor in the right breast. She presents almost no history: had a child at twenty-two, and her health had been good, when two years ago she noticed an enlargement of the breast. I think it dates further back, but, in any case, it now presents the following characteristics: It is as large as the head of a baby; it is exactly circumscribed to the thorax, where it is attached as by a sort of pedicle; the surface is uneven, rough; the skin is red; the consistence is unequal—it is hard in some places, soft in others; it is quite mobile, rolling on the pectoralis major. I will add that it is indolent, and there is no swelling of the glands in the axilla. It is, then, a real sarcoma, and, as there are some liquid parts in it, we will call it a cysto-sarcoma.

"Being able to show you both varieties—sarcoma and carcinoma—I take this occasion to make for you the differential diagnosis between them, as there is often a certain confusion made by those who have studied the old classification of Velpeau. Thanks to modern pathological histology, we can make the distinction aided by clinical facts.

"1. *March and Mode of Development.*—Sarcoma increases much more slowly, particularly at first. It may remain stationary for years; I once operated upon one that Nélaton had been consulted for some twenty-five years before; but when it does once take a start it will grow much faster than carcinoma, owing to the cystic cavities that develop in its interior.

"2. *Exterior Configuration.*—This takes in the form and volume. A confirmed sarcoma is unequal, lumpy on the surface.

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This is not the little unevenness you will notice in carcinoma, but big lumps as large as a hen's egg, or larger. Then the entire mass in sarcoma is detached in the form of a pedicle, which is not so in carcinoma, as there it is, as it were, flat on the chest. Sarcoma will grow to twelve or fifteen pounds in weight, but you will never see a carcinoma of such a weight.

"3. *State of the Skin*.—In carcinoma the skin becomes rapidly attached to the deeper parts; in sarcoma the adherence is much later. In carcinoma this gives rise to a tractus that is seen leaving the tumor and going into the derma, and when the skin is pinched up it gives rise to the sign known as 'orange-skin.' In sarcoma the morbid product approaches the skin and makes it thinner and thinner, just like an abscess that wants to break, and the skin is distended; in carcinoma it is retracted, drawn in, giving rise to the appearance of a quilted cover. In sarcoma the integument is often marked with large veins; this is not seen in carcinoma, but you do see white lines, which Dr. Labbé says are lymphatic varices.

"4. *State of the Nipple*.—In carcinoma the nipple retracts, and the end of the nipple seems to be absorbed. This is not so in the usual form of sarcoma, where it is not modified, except that it may be stretched somewhat.

"5. *General Aspect*.—They both have a tendency to ulceration, but the process is quite different. In carcinoma the skin fuses with the tumor and is destroyed; in sarcoma it gives way only by pressure of the lumps on its internal surface that belong to the morbid tissue. From these facts you will see that the ulcerated surface is quite different; in the carcinoma the border of the ulceration is hard and continuous with the tumor, but in sarcoma the border is thin and loose; it is about the same difference that exists between hard and soft chancre.

"6. *Consistence of the Tumor*.—In carcinoma it is hard, or at least firm, while in the other form it is much less so; but, above all, there are soft parts in the sarcoma, and even liquid parts from cysts inside.

"7. *Connection of the Tumor with the Mammary Gland*.—From the first, carcinoma fuses itself with it, while sarcoma will remain distinct from it, so that the gland is not destroyed, but simply flattened and atrophied.

"8. *Connection with Deep Parts*.—Carcinoma will adhere quickly to them, to the pectoralis muscle in particular, but the sarcoma remains apart from them.

"9. *Extension to the Lymphatic System*.—From the first the carcinoma will go to the glands, and the sarcoma hardly ever does so.

"10. *Return of the Tumor*.—Carcinoma will come back much



more certainly than sarcoma, and carcinoma will mostly return at a distance, while the sarcoma will come to the same place.

"11. *Influence on General Health.*—Carcinoma destroys it quickly, and it is very remarkable to notice that a sarcoma may be operated upon several times while the general health of the patient will remain satisfactory.

"12. *Symptoms.*—Carcinoma is generally painful, and sarcoma indolent.

"13. *Rules for Operating.*—In sarcoma, even the smallest, take away a portion of the healthy part also. I used to content myself with simply extirpating them, but I now recognize that it is bad practice; it is not needed to sacrifice all the gland, but to pass well over the limits of the tumor. Again, it is possible, as you will see me to-day, to measure beforehand a flap of the skin and cover the wound completely and get a reunion by first intention. This cannot be done in carcinoma, owing to the alteration of the skin itself."—Thomas Linn, M.D., Paris, France.—*Phila. Medical Times.*

—**PARAPHIMOSIS**—An interesting clinic was given on this subject at the Hospital Laennec, by Professor Nicaise, which is worthy of attention. Dr. Nicaise said, "You have just seen in No. 17 bed a young man who is to-day cured of a paraphimosis, and I will speak of it, as there are some points that you should know to understand its mode of production, its consequences, and its spontaneous cure, with the treatment that must be employed.

"Our patient had congenital phimosis, and, having retracted the prepuce, found that he could not replace it. When brought here we saw this state of affairs. There was an ulceration on the dorsal face of the penis whose borders were formed by the preputial mucous membrane on one side and the skin of the prepuce on the other, and its centre was constituted by the submucous tissue. The glans itself was swollen, and behind it was a ring or belt of tissue which was thicker below than above, and ulcerated behind in a deep furrow or sulcus. This furrow you remarked was not circular, but oblique from below forward; it was also more profound above than below; this is what we saw four days after the retraction.

"I made a slight effort at reduction; but the pain was severe and I feared producing a tear in the inflamed and ulcerated tissue. I at once introduced a pair of scissors and made a section. This incision at once became enlarged of itself, and I could have reduced it at once, but I always prefer to allow it to reduce itself, and the next morning most of the oedema had diminished, taxis was spontaneous, and to-day the patient is cured. The treatment of these troubles varies according to whether ulceration exists or

not. As long as there is no ulceration, try taxis. To succeed there are a number of ways. I prefer M. Le Fort's, who places the tips of his fingers behind the furrow and at the same time uses the thumb to press in the gland. Another process is that of M. Mauriac; he pulls back the skin, and, putting a finger under the prepuce, attempts to pull it forward over the finger, or a hair-pin with the bent end forward may be put under the prepuce and an attempt made to draw the constriction over it. Finally, there is the mode called total compression; this is to use a small Esmarch's elastic band, or even a linen band, and make compression from before backward, which will take all the blood out of the organ and often render the reduction easy.

"When there is ulceration, it is preferable to proceed at once as in this case or make a simple *debridement* by cutting across where the constriction is the thickest. One single incision is all that is needed, and it is preferable not to attempt any reduction at once, but to allow it to operate spontaneously. If desired, circumcision can be practiced; but I do not see any need of it. I will close by recommending you in these little operations, as well as in the more important ones, to insist on strict antiseptic treatment. The solution of carbolic acid used should be very weak, and the operation once made, apply a simple dressing of iodoform. No fatty substances are needed in attempting the reduction, as they do more harm than good."

[Phimosis and paraphimosis are conditions that enter closely into the life of every practitioner, and an early diagnosis may relieve the physician from an embarrassing position; while on the other hand if fortunate enough to discern the true state of affairs, may bring him a great deal of credit. It is always a good practice, in obscure cases, to examine carefully not only the genital organs of a male but a female child as well. If there are any indications of a local disturbance, have the matter attended to at once.]

—RELATION OF UTERINE DISEASE TO AFFECTIONS OF THE EYE.—By Thomas R. Pooley, M.D., New York.—Let us sum up what deductions may be drawn from a careful clinical analysis of these cases, which, for convenience, may be included in the following propositions:

1. In certain cases there is a direct relation between irregularities in function and diseases of the uterus and concomitant affections of the eye.
2. The eye affection may be merely functional, which is the commoner (asthenopia), or there may be organic disease.
3. Asthenopia exists in cases where there is no ametropia, apparently due only to the reflex effects of the uterine disturbance on the organs of vision.

4. In many of these cases there is paresis of accommodation.
5. In other cases of asthenopia in which ametropia is present, and the existence of uterine disease as well, the former is not always relieved by the correcting glasses.
6. Other functional anomalies than asthenopia may be observed, such as blepharospasm, diplopia, and functional irritation of the retina.
7. Long-continued reflex irritation from uterine disease may result not only in asthenopia, but, as already shown by Mooren, in atrophy of the optic nerve, and other organic changes.
8. Irregularity of circulation and venous hyperæmia about the climacteric period may be the cause of intra-ocular hæmorrhages.
9. Loss of blood from uterine hæmorrhage affects the nutrition of the optic nerve and retina, leading to dangerous results.
10. A variety of pathological conditions of the uterus may be responsible for the eye troubles, but they occur more often where the disease is of a chronic nature, as in displacements, lacerations of the cervix and other affections accompanied by congestion, and where the nature of the disease is such as to affect the normal process of menstruation.
11. The proper therapeutic measure to be adopted in such cases are: The rational treatment of the uterine disease; the correction of any existing ametropia; the temporary use of weak convex glasses when there is feebleness of accommodation. In some instances galvanism for the relief of supra-orbital neuralgia, and the use of tonics, proper food, and favorable hygienic conditions.—*N. Y. Med. Jour.*, Feb. 13, 1886.

—OPERATION FOR VESICO-VAGINAL FISTULA WITHOUT THE USE OF THE CATHETER IN THE AFTER-TREATMENT. Dr. Hugh M. Taylor.—Before the lamented Sims contributed so much to perfect the operation for vesico-vaginal fistula, the use of the catheter, immediately after the occurrence of the fistula, was thought by many to be the only means at all likely to bring about a cure.

Professor Simon of Heidelberg, has for some time contended that too much stress has been laid upon the use of all catheters after this operation, and also that the advantages of the metallic sutures and the necessity of absolute rest had been over-estimated. The patient we refer to had a fistula for twenty years, dating from her last confinement, which was instrumental in character. An examination showed that great destruction of tissue had resulted. The neck of the uterus looked as if it had been amputated close up to its vaginal attachment. There had either been destruction of its tissue, or the vagina was closely adherent to it, and covered it up; and the cicatricial bands had drawn or turned what remained of the os through the fistula into the bladder. It was only by fishing for it in the bladder that the exact location of the os

could be ascertained. The adhesions were old and strong, and no reasonable amount of stretching served to bring the cervix back into the vagina, and we did not think it probable that frequently repeated stretchings would bring about the result.

The fistula was as large as a silver dollar, and the only way we could get tissue enough together to close the opening was by attaching the lower border of the fistula to the remains of the posterior cervical lip, or, more correctly speaking, to the mucous membrane of the vagina covering it. The tissues were so changed and blended at that point that it was hard to tell one from the other. In doing this operation, the os was inclosed in the bladder, necessitating menstruation through that organ.

What made the operation much easier than it may appear, was that the vagina was short and very capacious, and the cervix pulled down low by the adhesions; this rendered it easy to bring the border of the fistula and cervix in apposition. A large surface was denuded, and eight or ten sutures were necessary to bring it together.

A piece of perforated rubber tubing, such as we had used successfully before, and seen used in a number of cases, was introduced as a catheter. For the first twelve hours it did its work well, and the bladder did not rebel against its presence. After that time, however, violent tenesmus came on, lasting several minutes at a time, or, in fact, until the catheter was expelled. Several times it was re-introduced, but quickly driven out again. At last, as a matter of necessity, we were obliged to leave it out, and allow the patient to pass her water, thinking this a lesser evil of two. We were under the impression that the catheter was the cause of the trouble, and hoped for its cessation as soon as we removed it. Our hopes in this respect, however, were not altogether fulfilled; for several days the bladder did not quiet down.

Frequently repeated doses of morphine and belladonna controlled the tenesmus to some extent; and finally, by the time the stitches were taken out, on the twelfth day, the desire returned only about every two hours, and was attended with but little pain and straining. Much to our surprise, the vagina remained perfectly dry throughout, and the union was found to be complete.

During all this disturbance, the urine remained free of mucus and phosphatic deposit. How much of this was due to the absence of the catheter, and how much to the free administration of lemonade, we are unable to say; but from the confidence we have in lemonade limiting phosphatic deposit, we are inclined to assign some effect to both.—*Archives Gynecol., Obstet. and Pediatrics.*

[Within the past two months we have operated twice for vesicovaginal fistula, using silk sutures and not using the catheter at all.

In both cases the results were perfect.—SKENE.]

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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No. 2.

MARCH, 1887.

VOL. IX.

THE DETECTION OF CRIMINAL ABORTION.

BY O. B. SANDERS, M. D., BOSTON.

(Read before the Mass. Surgical and Gynæcological Society.)

The great frequency of abortions at the present day, and the great number of both physicians as well as quacks who lend themselves out for this criminal purpose, is my only excuse for bringing this subject before you to-day.

I shall describe as well as lies in my power from study as well as observation, the various means used to produce criminal abortion, as well as the results or symptoms produced by their use. In the first place there is reason for suspicion that a miscarriage is taking place in a young healthy woman between the 2nd and 3rd month. By carefully questioning and considering the reasons given by the patient and comparing the time of the alleged cause, together with the symptoms described with the final result, remembering that spontaneous abortion begins without

shock, while criminal or forced abortion almost always begins with more or less severe shock or constitutional symptoms, will generally give us a correct diagnosis.

Among the operative means used, are use of female catheter, injections of various kinds into the cavity of the womb, use of bougie, whalebone, probe, and last, but not least, the use of electricity.

Whenever a criminal abortion has taken place by either of the above measures, the two marked symptoms almost never wanting, are, first, extreme hypogastric tenderness, often extending over whole abdomen, and together with this, there is always an increased frequency of the pulse, rarely under 100, while often reaching 120 or more. The temperature is also increased. These two symptoms of hypogastric tenderness, with very frequent pulse, are almost always present in criminal abortion, while in spontaneous abortion neither symptom is present, as a rule.

Differential Diagnosis.—In accidental or spontaneous abortion, a gradual climax of symptoms, thus: loss of appetite, depression of spirits, pain in loins, weight at anus or vulva, pain in breasts, followed by hæmorrhage and expulsive pains in uterus.

Instrumental Abortion.—Marked constitutional symptoms from the first; rigors, fainting or collapse, pain severe in hypogastrium, and marked tenderness on pressure.

Accidental Abortion.—Evidence of history, habitual abortion, previous ill-health or plethoric state.

Instrumental Abortion.—Evidence of history—previous good health; evidence of habitual abortion absent or doubtful.

Accidental Abortion.—As a rule pulse rarely reaches 100.

Instrumental Abortion.—As a rule pulse from 100 to 120 or more.

Accidental Abortion.—Generally there are no symptoms of inflammatory complications of uterus or abdominal viscera.

Instrumental Abortion.—Always symptoms of inflammatory complications, tenderness on pressure over uterus, os and cervix enlarged and tender to the touch.

If, therefore, the examination of the patient, or her friends establish the fact that the severe shock was among the initial symptoms, followed by expulsive pains, and if in addition we find marked hypogastric tenderness, we are at liberty to conclude that we have before us a case of forced abortion, notwithstanding the denial of the patient; and of course these facts are strengthened if upon digital examination, we found further evidence, as great heat and fulness of the vaginal passage, with extreme tenderness of the os uteri, corroborative of the above conclusions.

How can we distinguish a case of abortion at 6 weeks from dysmenorrhœa?

It detracts nothing from the acuteness of the physician to say that many cases may occur in which it would be almost impossible to discriminate between them. There may be expulsive pains in both, and tenderness of the abdomen, with fever, and the bloody discharge may clot in both cases. The patient also takes care that you can't find the ovum. However, there are but few cases in which forced abortion takes the mild course of a dysmenorrhœa. It is very seldom that you get the extreme tenderness over the hypogastrium nor the extremely sensitive os, with as high fever. The following table of differentiation will give us the most important symptoms.

Dysmenorrhœa.—Previous attacks; pain most severe just before discharge; pain relieved by the flow; pain more often ovarian than uterine, except in cases of retention; pain in loins and thighs.

Instrumental Abortion.—Absence of menses two or more periods. No previous history of dysmenorrhœa; rigors and severe constitutional disturbance; pain not relieved by the discharge; pain and discharge occur together; pain more

marked in uterus than ovaries ; tenderness acute over abdomen and uterus.

Dysmenorrhæa.—Fever not high as a rule.

Instrumental Abortion.—Temperature and pulse over 100.

Dysmenorrhæa.—No dangerous inflammatory symptoms.

Instrumental Abortion.—Dangerous inflammatory symptoms common.

Dysmenorrhæa.—History furnishes evidence of ill health.

Instrumental Abortion.—History of previous good health.

Dysmenorrhæa.—Manner of patient free from suspicion.

Instrumental Abortion.—Manner suspicious ; possibly expelled ovum may be seen ; great reluctance to vaginal examination.

In addition to the above symptoms in case of instrumental abortion by use of probe or bougie, you would be apt to get more or less discharge of a thin sanious kind for a few days previous to the symptoms described under the first differentiation given.

Before the crime of abortion was brought within the strict borders of a science and art, it was perpetrated by means of drugs, which by direct or indirect action rendered the womb unable to hold its foetal contents. It is, however, a safe statement that every woman, married or single, when she suspects herself pregnant resorts to the full use of drugs before she applies to the abortionist, and the opportunities a woman has to obtain drugs of this nature are many. There are more than twenty different preparations advertised and sold for this very purpose to my own knowledge, and how many more it would be hard to estimate. The liability of an abortion terminating fatally produced by the use of drugs is far greater than when produced by operative interference. Dr. Taylor in speaking of the use of drugs used as abortifacients, says : " They rarely answer the intended purpose, and when this result is obtained, it is generally at the expense of the life of the mother." I think the assertion of Dr. Taylor is too strong, as, without doubt, many cases of

abortion from drug action, have occurred without being fatal to the mother, as almost every physician has had more or less proof of this statement in his own practice ; still, as I said above, drug abortion is certainly more dangerous than operative abortion.

An abortion produced by the use of drugs is more difficult of detection than that produced by operative interference, as it resembles more closely an abortion from natural causes.

Abortifacients may be divided into three classes.

1st. Those which act directly on the womb.

2nd. Those which act reflexly by the irritation of some adjoining organ.

3rd. Those which are combined, so as to unite the action of the first and second class.

Those abortifacients which act directly upon the womb are few in number, namely, ergot and cotton root. Let us first see when and how far the womb is capable of this direct stimulation of its expulsive power. There are well-founded doubts about the power of ergot alone to produce abortion in the first three months of gestation. However, ergot will hasten expulsive action in the impregnated womb whenever any reflex irritability is already established because it is a muscular organ. All women throughout the land know that ergot "will bring on the pains," so it generally plays an important part in abortion, as it will usually be taken after drugging by pills, tea, etc., including the gin bottle.

Ergot is a promotor of neurodynia. It will be difficult at times to separate this neurodynia of ergot from what may be called the normal neuralgia of abortion, unless we remember that ergotine neurodynia attacks nerves not usually liable to pain during labor or abortion.

Romberg says: "It seems as if pain were the prayer of the nerve for healthy blood." The neurodynia of ergot seems to depend upon a deficient blood supply, owing to its action in lessening the calibre of the uterine bloodvessels.

It really produces an anæmia of the nerve. Ergot also causes a contraction on the non-striated muscular fibre of the minute arterial coats which brings about a nerve anæmia which causes pain in its trunk and peripheric terminations. The selection of this ergotine neurodynia seems especially to be the nerves of the extremities.

Pain in spontaneous abortion is the symptom which precedes and accompanies the expulsive stage of the accident, while ergotine forced abortion leaves a long lasting or lingering pain after expulsive action has ceased, also the ergotine pain is often excruciating out of all proportion to the expulsive efforts. Severe uterine or ovarian pain taken singly in spontaneous abortion is rarely seen except in the latter stages of the process, while ergotine neurodynia is apt to be excited at once, in early stages among the first symptoms, of course being present at a time when the expulsive pains would not be present, judging from the condition of the os.

This condition taken with the possibility of neurodynia of the extremities, face, etc., is at least presumptive evidence. Another symptom will often be of service as assisting in detecting ergotism, namely, dilatation of the pupils, and in addition to this, we usually find the pulse much lowered in its rate, often falling 20 or more beats from its normal standard, frequently reaching 55 beats per minute. Amal found that in one case where the pulse had fallen from 84 to 62, that it began in an hour after the use of ergot and fell at the rate of 8 beats per minute. The action of ergot is thus isolated from all others likely to be used as an abortifacient by this lowering of the pulse. Together with a lowered pulse, we get a corresponding low temperature. Finally the sphygmograph has shown, according to two authors, first, a systolic distension; second, increased arterial pressure; third, irregularity in the heart's action.

Cotton root or gossypium herbaceum is the other drug in common use as a direct abortifacient. The action of this

drug is still a very disputed question, some maintaining that its emmenagogue and abortifacient powers are marked, while others maintain as strongly that it is perfectly inert in its supposed specific action. Dr. Boushelle wrote about it in 1840, stating that the slaves in the south used it successfully as an abortifacient, and that it did it in a kindly way without serious consequences. The only effect which would lead us to suspect its use is the operation of the drug as a narcotic when freely used. As women in this condition would naturally be over anxious, restless and wakeful, the drug in large doses produces a drowsy, stupid condition wholly at variance with the supposed natural condition. If then the cotton root were used freely, we should have a stupid, drowsy condition hard to explain and would at least be very suspicious.

Among the reflex abortifacients may be mentioned aloes, black hellebore, savine, tansy and rue.

Aloes is seldom given except in combination, but will be found as a leading ingredient in all the emmenagogue pills. Of course a powerful cathartic effect is produced by these pills. The circulation and innervation of the pelvic contents is profoundly affected by the excessive medication with this drug aloes. The hyper-catharsis produces great tenesmus, syncope with trembling limbs. The long continued use of this drug causes excessive tenesmus, with heat and fullness, which is the result of rectal engorgement. The vaginal, uterine and middle hæmorrhoidal arteries arise from the same trunk, the internal iliac, also they have a common blood supply, therefore it is difficult to conceive how great hyperæmia of the rectal walls could occur without the womb and vagina partaking of the same condition. The old writers considered aloes an emmenagogue on this theoretical ground. The excessive irritation produced by its prolonged use is just the condition necessary to excite reflex motor action in the neighboring organs, as womb, etc. The womb and rectum have great nerve connection which also

favors this condition. There is a ganglionic connection from the hæmorrhoidal plexus of nerves with the womb. Therefore these two conditions, engorgement from common blood supply with the rectum and motor action from nerve connection, render the pregnant womb highly likely to throw off its contents if this drug action is continued long enough.

We must remember the effects the drug produces when pushed to the abortive success in order to detect its use.

The circulation is stimulated by it. There is heat of surface with quickened pulse. Urine is scanty and high colored, evidently an intestinal hyperæmia will be present. Face flushed, different from the action of most purgatives. Its local effect is first manifested by the excessive painful tenesmus. Pain in back, heat and fullness in rectum and anus. Frequent micturition, marked and peculiar odor of the discharge from aloes; therefore, if in addition to the usual symptoms of abortion, we should get a history of rectal tenesmus, with heat and pain in anus, frequent scanty micturition, history of increased heat of skin and quickened pulse, perhaps pasty fluid dejection streaked with blood, we should be justified in deciding that aloes had been exhibited, either singly or in combination.

Black hellebore.—This drug is usually found in many combinations, but it has no emmenagogue effect save its action on the rectum as a cathartic. Croton oil, gamboge, elaterium, etc., might be as well used. Its action would be a slow acting cause. In the history of such a case there would simply be scanty urine, thirst without fever, a record of recurring fluid evacuations at intervals, together with more or less shock. Its detection would always be doubtful.

Savine.—This drug has a two-fold power as an abortifacient. It has an exciting action on the rectum and bladder, thus acting reflexly on the womb, also it causes turgidity of the pelvic viscera. Letheby says that it has special action on the vessels of the lower bowel, and this action extends to

the adjoining organs. Vogt says: "It produces an apoplectic condition of the fœtus." Of course this toxical effect producing venous engorgement is favorable to abortion.

A large and dangerous dose of about 15 drops would usually produce the following symptoms; violent pain in abdomen, vomiting, severe cathartic action, tenesmus, stranguary, burning in stomach, bowels, rectum and anus. Flushed face, severe headache and temporal constriction: occasionally salivation would be produced. The urine gives forth the odor of savine very distinctly; skin hot, dry, with increased temperature; usually tenderness over abdomen; throbbing of carotids.

The detection of abortion from the use of savine depends mostly upon the effects of the drug upon the system, rather than in any peculiarity of the abortion itself. Its odor in the urine, in the breath, etc., of the patient, severe headache, flushed cheeks, and especially the constriction like pain round the temporal region of the head, and, if in addition we should get the cathartic effect, pain and flatulence, with the peculiar burning at the anus, and added to this the frequent micturition, we would have positive proof of the drug action.

Tansy.—This drug is both common as well as very popular among women as an abortifacient. It resembles savine in its urinary effects, also in its venous engorgement of the pelvis, but their resemblance ends with these two effects. Tansy seems to produce this venous congestion through its action over the vaso-motor nerves. The action of tansy is threefold: First, as a stimulant tonic. Second, as a stimulant to the venous circulation. Third, as a violent poison to brain and spinal cord. The second action, or its power as an excitant of the venous circulation, brings it solely into the rank of an abortifacient. It seems to produce a sort of uterine apoplexy, thus rendering the womb unable to hold its contents. It has no direct action as an expulsive force, but by causing almost an uterine apoplexy or a condition so near it that

the womb is roused to action. Women from taking it, soon feel a heat and fulness though the hips, which increases till they finally have a show. For the purpose of detection of the drug, we should place on the list its peculiar odor from the urine, and after a large dose, it may be noticed from the breath. Considerable dilatation of the pupils associated with the tansy odor is more conclusive. Pricking of the limbs may be present, also numbness at toes.

Rue.—When this drug is given, usually fearful pains in stomach, with vomitings, nervousness with partial unconsciousness, come on at times. Its action is not dangerous, like tansy or savine, yet many women claim that it is effectual every time. The oil of rue is so adulterated that the successful cases are through infusions of the leaves or fresh root of the plant. In an abortion where this drug was used in excessive doses, there would result syncope, drowsiness, a reduced pulse, nervous restlessness, with diuretic effect, of course being difficult of detection.

The proprietary nostrums sold in pill form are composed largely of aloes, iron, and powdered savine, or at least aloes is the prominent ingredient. All the so-called periodical pills produce in large doses a cathartic effect. From these pills, if aloes is the chief ingredient, we shall get its action as if given simply, also a separate action of savine as already described. Having given the specific action of each drug separately, in combination it will produce the same effect, namely, aloes will have its peculiar effect, savine its peculiar effect, etc.

There are also periodical drops composed largely of the oils already described, as tansy, rue, etc. The separate description of these can always be applied to the several compounds.

THE MUTUALITY OF UTERINE AND NERVOUS DISEASES.

BY F. C. RICHARDSON, M.D., BOSTON.

(Read before the Mass. Surgical and Gynæcological Society.)

The great problems of life have in all times had a profound influence upon the heart and mind of man. Whatever concerns the prolongation of life, or the increase of the capacity for enjoying it, the prevention or cure of those modified vital actions which we know as disease, has always commanded the interest of mankind, and he who devotes the well-directed efforts of a life to the furtherance of these objects is well worthy the gratitude and honor of the world. His mission is as extensive as humanity whatever form it takes. There is no one to whom accurate and incessant observation is so essential; and while we can not hope to master in the brief span of a life all of the delicate adjustments of vital operations, and the subtle causes of disturbance of those operations, the importance of the issue at stake, should be sufficient incentive for us to put forth every effort to fathom the deep sea of medical science; to cast the lead and draw up at least a little sand from depths we shall perhaps never reach with our dredges.

It is with this spirit that I approach the subject of the mutual relationship of uterine and nervous diseases. The influence of one over the other was a fact, like so many others in medicine, recognized long before it received a correct explanation. The ancients saw only uterus when regarding hysteria. Hippocrates described the hysterical paroxysm and its accompanying disorders under the name of "strangulation of the uterus." Nervous diseases generally, when in the female, were supposed to originate in some way from the abnormal movements of the uterus. It was believed that this accommodating organ could wander at will throughout the body, doing all manner of mischief.

Hippocrates asserted that it was the origin of six hundred evils and innumerable calamities.

We are inclined to smile at this somewhat fanciful and bold assertion, thoughtless for the moment of the fact that, following the fashion of the times, the tendency of to-day seems to be toward the Hippocratic way of thinking.

While no one in the light of present knowledge denies that the association of neuroses with disordered conditions of the female reproductive organs is frequent, I fear most of us have but vague and ill-defined ideas as to how such association comes about, or which is cause and which effect. The gynæcologist with a jar full of ovaries, the removal of which has apparently cured a whole train of nervous conditions, from simple headache to insanity, is perhaps excusable for thinking that spaying is the remedy, *par excellence*, for most of the ills to which female flesh is heir. While on the other hand the neurologist, arguing from his experience, may be equally absolute and affirm that neuroses have no more to do with the organs of reproduction than with any other of the female body, and that it is no truer to say that women are neurotic because they have wombs and ovaries, than that men are gouty because they have beards.

It is to a rational middle course that I wish to direct you. While so doing I may teach you a very little, but I hope much more from the trains of thought I shall suggest.

It requires but a glance at the anatomy of the utero-ovarian nerve supply to trace the intimate connection of these organs with the great nerve centres. The nerves of the uterus and ovaries arise from the coeliac plexus through the intervention of the renal plexus, which, through its inferior ganglion, is distributed to the ovaries, and spermatic or genital ganglia. These genital ganglia, four in number, receive two large branches from the great sympathetic, and give off a great number of nerves to the ovaries. Formed of the principal branches of these ganglia, with the addition of small branches from the four lumbar ganglia of the sym-

pathetic, is the great uterine or lumbo-aortic plexus. This plexus divides on the promontory of the sacrum into hypogastric plexuses which are joined by branches from the terminal ganglia of the sympathetic, and are distributed to the lateral borders of the cervix uteri. There is a large cervical ganglion on each side of the neck from which arise the greater number of the uterine nerves, the rest coming directly from the hypogastric plexus. The cervico-uterine ganglia receive their afferent branches not only from the hypogastric plexus, but also from the second, third, and fourth sacral pairs.

Thus you see that the nerve supply is derived from both the cerebro-spinal and ganglionic systems, and so intimate and intricate is their anastomosis that it seems impossible to distinguish the fibres of one from those of the other.

Remembering the origin of this network of nerve filaments, and the physiology of these two great nervous systems, it is not difficult to appreciate the fact that any irritation of the ovaries or uterus may give rise to nervous phenomena in any part of the nervous tracts or their sympathies.

It would be inconsistent with the limits and purpose of this paper to attempt a complete enumeration of the neuroses which may be reflex from disorders of the generative organs, and I shall content myself with the brief mention of a few conditions which, because of their frequency or interest, have presented themselves to my mind.

And, first, let us speak of that Protean malady, hysteria. The very name, derived from the Greek *ὑστέρα*, the uterus, denotes the implicit belief in a uterine origin which prevailed when the condition was first described. In time the idea that the uterus was the exclusive seat of hysteria was in a large measure supplanted by the view that the sexual organs in general were concerned in the production of hysterical phenomena. Romberg defined hysteria as "a reflex neurosis caused by genital irritation;" and this

definition well expresses the standpoint from which the affection was discussed until a comparatively recent date. This belief arose naturally from the fact, which is as true to-day as it was then, that hysteria is rarely met with in the female without some co-existing functional derangement of the uterus or ovaries. I say functional disturbance rather than disease, for usually it is some condition of pain, excitement, or irritation, nervous or vascular in some part of the genital organs; indeed, true hysteria is one of the rarest of the nervous disorders occurring as general symptoms of uterine *disease*. It is the irritation arising from functional disturbance that forms the starting-point of hysteria in pale, nervous and emaciated women who are already predisposed to it.

I do not wish to be understood as maintaining that hysteria is to be looked upon exclusively in its relations to the genital organs; modern scientific investigation, and the increasing frequency of this affection in males, have, I think, fully exploded this ancient view.

Courty, the acknowledged exponent of the French doctrine, has well expressed the most advanced thought upon this subject in his admirable work, "The Uterus, Ovaries and Fallopian Tubes," in which he says: "If helped by the light which recent researches have thrown on the physiology of the nervous system, we endeavor to discover the relative share of influence exercised by the nerves and by the uterus on hysteria, we must admit that the disease is really a neurosis, that is to say that it is due to a general derangement of innervation in which the whole nervous system partakes with effects varying in form and degree according to the exciting cause and to the special idiosyncrasy in each case. But we must remember that these symptoms so varied in detail and yet so similar as a whole are only manifestations of the reflex action of brain or spinal cord, the starting point having been irritation in some other organ, generally in the generative system."

But time will not permit us to dwell longer upon this topic, and in leaving this most interesting subject I may summarize the conclusions arrived at thus : Hysteria is not properly speaking a disease of the uterus or ovaries, but as these are perhaps the most subject to functional derangement of the female organs, they are a most frequent source of irritation in hysterical patients, and this fact should not be forgotten in the treatment of this class of cases.

A condition closely allied to that which we have just been discussing is the train of nervous phenomena consequent upon laceration of the cervix.

I believe it is generally conceded that all lacerations of the cervix entailing pathological changes are the result of parturition. A subinvolution of the uterus is usually the first of these changes ; this in time becomes hyperplasia, when the minute nerve filaments are compressed by the thickened areolar tissue, and the multitudinous nervous phenomena result. The terminal nerve filaments in the cervix are also compressed by the cicatrix, producing through the medium of the sympathetic system, neuroses in any part of the nervous tract.

As examples of these may be mentioned reflex neuralgiæ, chorea, hypersensitiveness, loss of memory, tearfulness, fear, apprehensions, hysterical attacks or fancies, and the vagaries almost of insanity, while melancholia is not at all infrequent.

The connection between the laceration and neuroses is proven by numerous recorded cases where trachelorrhaphy has entirely relieved the nervous symptoms ; and where these symptoms do not yield to careful and continued treatment, and no other tangible cause can be discovered, a laceration of the cervix should be sought for, and if found, much benefit may safely be expected from its repair.

A neurosis reflex from the female sexual organs, which is of most common occurrence, and too rarely understood as such, has been recently described by J. Milner Fothergill in so graphic a manner that I take the liberty of

quoting at length from his article on "Cardiac Neuroses." *
"There is one form of palpitation which has such distinct relations and is so commonly met with (when the doctor has learned to see it) that it deserves a few words. It is ovarian in its origin. The patient, usually a woman of child-bearing age, complains of more or fewer of the following symptoms, sometimes one being more prominent than the other; she has pain in her side with palpitation. She has vertical headache with sense of weight and lowness of spirits. She has nausea, indigestion, and often vomits her food; yet her tongue is clean. She may be said to have inflammation of the stomach, and her friends are gravely alarmed about her; and every medical man of experience could relate such cases. She has leucorrhœa and often menorrhagia, with a large heavy uterus. She cannot hold her water properly, and spasm is readily and easily produced (the centres for the bladder and the reproductive organs lie near together, and are therefore affected by the same cause). The cause of all these linked phenomena is an irritable ovary. Usually the ovary can be found swollen and exquisitely sensitive to the touch. Pressure over the ovary makes the patient feel deathly sick, and as if she would faint. Her sensations are reflected on her face. This is a malady, with distinct and unusually well-marked features, yet it has not found its way into our text-books. It is common enough to well repay study; and in a well-marked case, when symptom after symptom into the arcana of her most private sensations, is asked after, the woman stands as if in the presence of a magician. Such apparently widely separated phenomena have apparently no connection with each other; yet their causation is identical, viz., a troublesome ovary. Waves of nerve irritation set up in the ovary travel along different nerve fibres, and find varied terminations. In one case they set up forcible contractions in the stomach, in another they are felt in the terminal fibres of

* *Vid. Med. Record*, vol. 26, p. 85.

the intercostal nerves as gusts of neuralgic pain. In all they keep the uterus in a state of turgescence, and in most there is leucorrhœa and heavy menstrual losses."

I have no doubt you will recall many such cases. My experience has been that they do not yield readily to treatment, but allaying the ovarian irritation, perhaps with the aid of the constant current, will accomplish much toward their relief.

If neuroses such as have been described can be caused by reflex uterine or ovarian irritation, and be permanently relieved, as has been shown, by the removal of such irritation, we must admit the possibility of a neurosis in any part of the body, no matter how far distant from the pelvis, being symptomatic of uterine or ovarian disease, and such neuroses occurring at the menstrual period, would I think justify one in requesting a vaginal examination.

But in the interest attaching to the discussion of the utero-ovarian origin of nervous disease, we must not forget that there is another side of the picture, namely the neurotic origin of diseases of the uterus and ovaries.

The same intimate connection with the great nerve centres which permits of neuroses reflex from the generative organs is also responsible for the influence of deranged nerve function in the production of morbid conditions of those organs. This influence may be exerted either directly by transmission of nerve irritation, or indirectly by disturbed vaso-motor function, thus interfering with nutrition.

It is to this latter that I wish especially to call attention, for I believe vaso-motor disturbance to be a factor in the production of uterine disease, the importance of which has not been sufficiently appreciated by the majority of gynecologists.

By a delicate adjustment of nervous impulses transmitted through the vaso-motor nerve fibres, the contractile elements of the bloodvessels are capable by contraction or relaxation of causing constriction or dilatation of the calibre

of the vessel. Arteries in such a state of constriction as under ordinary circumstances is normal to arteries whose vaso motor fibres have not been divided and which are otherwise in a normal condition, are said to possess tone.

Arterial tone both general and local is a powerful instrument for determining the flow of blood to the various organs and tissues of the body, and thus become a means of indirectly influencing their activity. We should accordingly expect to find that vaso-motor nerves were connected with, and arterial tone regulated by, the central nervous system, and experiment proves this to be the case.

Far more important, however, than the maintenance of a normal tone, is the power which the central nervous system possesses of varying the tone of this or that artery or group of arteries; and the exercise of this power may be called forth in either direction, in the way of constriction or in the way of dilatation, by means of nervous impulses either originating in the central nervous system itself, or started by afferent impulses passing up to the central nervous system from any part of the tract.

With these physiological facts in mind we have only to remember the extreme vascularity of the female reproductive organs, to be impressed with the especial liability of these organs to influence by vaso-motor disturbance.

That the women of to-day are constantly exposed to such disturbances of nerve function by reason of the ruinous social system in vogue in our great cities, is a lamentable fact, realized by no one so well as by the physician.

Let me present to you a familiar picture which I think you will recognize as true to life.

A fairly nourished girl of perhaps sixteen or eighteen years devotes five hours of the day to mental labor in school. She arrives home, and after a hasty lunch her busy brain is exercised to its utmost in the preparation of the lessons for the following day. Dinner having been eaten hurriedly in order that she may have time to dress, she is

driven in the evening to the ball-room, where in hot and heavy air whirled into sensuous gusts of varying perfume by a score of floating visions, every thing conspires to the most profound emotional excitement. Here under the softened gaslight, this already bedazzled girl, locked in the close embrace of her partner and keeping time to the soft dreamy music, is borne away in the delirious maze of the modern waltz, which in its damaging intoxication of the senses is too often I fear a powerful rival of the demon alcohol.

Imagine this nervous tension, to speak of it mildly, continued for hours until at last this victim at the altar of society is escorted to her home and with the rapture faded from her eye, the flush dying from her cheek, enervated, limp, listless, worn out, she sinks into a sodden slumber, to be with difficulty aroused in a few hours for school, totally unfitted for the day's labor which her weary brain performs under protest.

This severe shock to the entire nervous system is repeated many times during a season, and is responsible for many more cases of nervous exhaustion than is our much abused school system.

And with the rest of the jaded nervous system, the vasomotor function has received its full share of injury. Together with other vascular tracts, the utero-ovarian blood supply is perverted: there is increased arterial tone causing regional anæmia, amenorrhœa, etc., or loss of tone encouraging a copious flow of blood to these organs, thus giving opportunity for an increase in the total interchange between the blood and the tissue, hence we have hyperplasia with increased weight of the organ and consequent displacement with all its horrid brood of symptoms so familiar to the modern physician, and which when brought about by the disturbance of nerve force just mentioned can never be cured by local treatment until the primary cause is removed, and the nervous system toned up.

These cases require first of all proper hygienic and die-

tetic regulation, with the soothing effect of galvanism or the tonic effect of the induced current; and to complete the cure a voyage to the Western Islands which constitute our "South of France." A month's sojourn in the delightful climate of Fayal, which is our Madeira, free from the harassing requirements of omnipotent Fashion, and a diet consisting largely of grapes, will do more for them than postural treatment or pessaries.

This hasty consideration of the mutuality of nervous and uterine diseases will serve to introduce a subject which merits your most careful and thorough discussion, and if this paper be instrumental in bringing this about it will have accomplished its chief object.

THE ACTION OF HYDRASTIS ON THE BLOOD- VESSELS OF THE GENITAL ORGANS.

E. M. HALE, M. D., CHICAGO.

When, several years ago, Prof. Shatz announced that hydrastis had the power of contracting the bloodvessels of the uterus, American physicians were taken by surprise.

Although this indigenous drug had been extensively used by botanic and eclectic physicians, none had ascribed to it any anti-hæmorrhagic properties.

When revising the last edition of my *Materia Medica of New Remedies*, I failed to find any reports of the use of hydrastis in any kind of hæmorrhage, or in any condition of the uterus which would lead to hæmorrhage. Its use in hæmorrhoids was supposed to be due to its value in constipation. It seems that Shatz was led to its use in hæmorrhages and uterine fibroids from the results of his experiments on animals. He found that it not only caused persistent contractions of the arterioles of the uterus, ovaries and other pelvic bloodvessels, but uterine contractions as well. His

last observation led him to believe that hydrastis is an oxytotoxic, *i. e.*, capable of causing contractions of the muscles of the uterus.

Later experiments, however, have shown that the "peristalsis of the genital tract seen in animals Shatz considers due to the strongly contracted bloodvessels, and not to muscular contractions." This peculiar power of hydrastis makes it a remedy peculiarly unique, and gives it a high place in uterine therapeutics.

In presenting its curative sphere, I shall take up each pathological condition to which it is applicable, with practical observations.

(1.) In *uterine myomata*. Shatz found it far superior to ergot. It controls the *hæmorrhage* more effectually than ergot without causing the pain, gastric disturbance or nervous symptoms which follow the use of the latter. During the last three years I have treated seven cases of uterine myomata, with hæmorrhage, with hydrastis, with the uniform result of preventing the frequent attacks of hæmorrhage. Not only this, but by causing a persistent contraction of the bloodvessels which supply the tumors their nutrition was cut off, and they steadily decreased in size. Meanwhile the general health of the patients always improved. In one instance the woman, with a long fibroid in the posterior wall of the uterus, after being under treatment for two months, she became pregnant (her youngest child was eight years old) and passed through her pregnancy without accident, and was delivered at full term of a fine healthy child. The tumor, after confinement, was as large as an orange. She was put on the hydrastis again, and the uterus went through perfect involution, the tumor decreasing one half in two months.

(2.) In *concentric hypertrophy of the uterus*, such as occurs after confinement, or at the change of life, and which bleeds upon the slightest irritation, or after a miscarriage. This condition is removed by hydrastis, if its use is persistently

used for several months. This condition does not resemble real areolar hyperplasia, but rather sub-involution. The bloodvessels are enlarged and relaxed, owing either to atony of their muscular walls or deficient innervation from vaso-motor paresis.

(3.) *In hyperæmia of the genital organs, not inflammatory, but passive and chronic.* In such cases hydrastis is to the latter what belladonna is to the acute. Under its use the passive stasis is removed, and there is but little tendency to relapses. Its internal use can be aided by the local application of the medicine applied on tampons of antiseptic wool or absorbent cotton (the former to be preferred). Instead of causing uterine pains, as does ergot, hydrastis is actually a sedative to the congested tissues.

(4.) *Metrorrhagia and menorrhagia* are both under the curative influence of hydrastis. In the former when appearing as profuse flooding after labor, and *not* due to deficient muscular contraction, but deficient contraction of the bloodvessels, hydrastis is specific. This is a condition not as rare as may be supposed. Hæmorrhage does often occur after delivery, when the uterus is contracted, and this variety is often obstinate and persistent, but is soon controlled by proper doses of this medicine. In *metrorrhagia*, or profuse menses, either premature or irregular, especially when the uterus is enlarged, relaxed and congested, hydrastis is greatly superior to calcaria and senecin, and is rivalled only by sabina and trillium.

(5.) *Acute and chronic pyo-salpinx*, according to Shatz, is generally benefited by hydrastis; also chronic peritonitis and ovaritis. It has been lately recommended in chronic pelvic cellulitis. These conditions it doubtless benefits by restoring the normal calibre of the distended bloodvessels.

(6.) *In cancer and malignant diseases of the uterus* we ought to expect good effects from this medicine. It may not remove the disease, but it certainly does mitigate the severity of the pain and hæmorrhage. This I can testify to

in many instances which have occurred in my practice. In prolapsed, congested and painful ovaries I have found that its topical application has been followed by the best results, when it is persistently used. One great advantage which hydrastis possesses over all other remedies is its wonderful restorative qualities. It increases the appetite and digestion. It improves assimilation of food and aids in imparting nutrition to all the tissues of the body.

Dose and Methods of Use.—This is a very important matter. Shatz recommends, from practical experience, that the dose of the fluid extract or tincture, shall be from 15 to 60 drops, three times a day. This is the average dosage. I determined to test the utility of smaller doses. I found that even in sensitive subjects, the 3x or 2x dilution was practically without effect. The 1x in a few cases, seemed to produce favorable results.

I finally was obliged to nearly approximate to the dosage adopted by Shatz. I fix the minimum dose, capable of curative action, at ten drops of the 1x every 2 or 3 hours. The maximum dose, as 30 gtts of the mother tincture 3 or 4 times daily. I have tried other preparations—viz: the “fluid hydrastis,” a preparation made without alcohol, and supposed to contain all the constituents of the drug. I did not find this superior to the tincture. *Hydrastin* did not act as satisfactorily as the tincture. Some recent observations of Shatz and Prof. Mays would seem to prove that *berberina*, the chief constituent of hydrastis, is *not* the agent which causes the contraction of bloodvessels, although the phosphate of hydrastis is supposed to act favorably. If by the “phosphate of hydrastis,” is meant the phosphate of berberina, I doubt its possessing such power. I think the observer intended to refer to the phosphate of *hydrastia*. Berberina is the *yellow* alkaloid of hydrastis root. *Hydrastia* is the *white* alkaloid. In this white alkaloid I believe to reside the specific action on the bloodvessels discovered by

Shatz. Prof. Mays in his experiments found this to be the fact, while berberina had no such action.

The muriate of hydrastia is the most eligible preparation because it is very soluble. The dose is from $\frac{1}{100}$ to one grain. I have found the 2x trituration sufficient to establish curative action. Only in a few cases have I used the 1x, and rarely, granules of $\frac{1}{4}$ grain.

The intense bitterness of the tincture is an objection to a certain class of patients. This can be disguised by giving it in syrup of wild cherry. The "hydrastin" of some manufacturers contains the yellow and white alkaloid—mixed. This can be given in capsules or coated granules. The dose being $\frac{1}{4}$ to one grain. It is my conviction that the *hydrastia*, or white alkaloid, will be found the really efficient constituent. For topical application, on tampons or in vaginal suppositories the tincture, or "fluid hydrastis" can be used. Both are objectionable on account of the yellow stain which they leave upon the clothing. The preparation known as "colorless hydrastis," is an elegant one. It leaves no stain; contains no alcohol, and acts as a local sedative.

It is composed of the white alkaloid, with other constituents of the root, which have not yet been isolated, but possess decided sedative and alterative power, especially on mucous surfaces. Applied to mucous membranes it resembles in its anæsthetic action *cocaine*. It blanches the surface, and unless used too strong, is not followed by injection of the bloodvessels, or irritation.

The strength of tincture hydrastis or fluid "hydrastis" should not exceed 3j to 3j of water, or water and glycerine equal parts. "Colorless hydrastis" should be used about the same dilution. Tampons saturated with these preparations should be applied once or twice a day. To avoid fœtor, if absorbent cotton is used, add 3j of boracic acid to each ounce of the diluted lotion.

CANCER OF THE UTERUS.

BY GEO. H. PAYNE, BOSTON.

(Read before the Massachusetts Surgical and Gynæcological Society.)

We have but little doubt at the present time but what the origin of these growths are purely local, and dependent upon some form of perverted nutrition. It is now generally supposed that epithelioma is caused by an injury to the cervix during labor, and follows an effort of nature to repair the damage done at that time. For a long time the trouble is dormant, and remains so until some change takes place in the system, and the surrounding tissues become invaded, the lymphatics and bloodvessels become loaded with that poison that disseminates itself throughout the whole system.

This poison, this cancerous degeneration, or material, becomes arrested in the lymphatic glands, clogs them up, and the consequence is that it cannot be thrown out of the system, as their functions are destroyed, and the disease progresses until it becomes constitutional. It is impossible to tell how long these troubles remain dormant before they begin to show unmistakable signs of their existence. "Emmet and many other writers says for an indefinite period," probably until near the menopause, as we find that many are developed at that time, undoubtedly due to the changes that take place in the system, as the menstrual flow ceases. If it is a fact, as Emmet says, that the majority of cases of epithelioma occur in women that have been pregnant, then it must be a fact that the trouble remains local for a long period in many cases, as it is usually the case that it is years from the time of the injury before the cancerous development presents itself. Emmet again says that he never knew a woman to have any form of epithelial cancer of the uterus unless she had at some time been impregnated, and that all or nearly all cases of epithelioma, or cauliflower growth, have their exciting cause or origin in a laceration of

the cervix. This tends to prove that they depend upon some form of perverted nutrition, and an effort of nature to repair the damage to the cervix. I believe that it is not necessary to lacerate the entire muscular tissue, but that it may result when the mucous membrane is alone involved, for the reason that many cases of cancer are found where the cervix was not lacerated to any great extent, in fact, where the muscular tissue was not ruptured at all. It seems quite probable that the cicatricial tissue formed after an injury to the cervix during the first labor early in life, should remain dormant until the change of life, and be developed at that time.

These growths are first benign in their character, but as they grow older they become malignant, and as that material becomes absorbed, the constitutional symptoms appear. The prognosis in these cases is not a very favorable one, all will admit, but at the same time we must admit the force of the argument, that if the diagnosis can be made while the trouble is local, and situated within that portion of the uterus that is accessible to surgical operations, that we have a fair chance of curing them.

If it is true that the cicatricial tissue and mucous cysts found in an old lacerated cervix degenerate into epithelioma, then the operation for lacerated cervix must not only cure the condition that causes it, but prevent such cases becoming cancerous, making that operation of more than ordinary value. There is undoubtedly truth enough in Emmet's statement to warrant the gynæcologist in paying especial attention to these diseases of the cervix, not only with a view of curing epithelioma in its incipient stage, but to prevent it before it becomes developed. Much care should be exercised on the part of the gynæcologist, and all others that heal female troubles, not only to diagnose cancerous tendencies, but to anticipate their liability to be produced by any existing conditions, remembering that all injuries to the cervical mucous membrane may lead to serious

results. The diagnosis of cancer after it has become fully developed is easy enough, but at that time it is often the case that it has progressed so far that removal is impossible, or of no avail. It is advisable in all cases where there are frequent hæmorrhages to look carefully after the condition of the uterine organs. Any sudden hæmorrhage accompanied by an offensive watery discharge, is always an alarming symptom, and indicates a destruction of tissue. Much has been written in regard to the treatment of cancer, and all advise removal as the only thing that will in any way act as curative.

I believe that although many good results are obtained by the methods recommended by other writers, that there is a better way to remove either epithelial or scirrhus growths of the uterus, than with the knife or cautery, and that is with escharotics. My reasons for this are that all hæmorrhage is prevented both at the time of and after the operation, which is usually considerable, and should be avoided if possible, as it weakens the patient to a considerable extent. Then again the patient is not necessarily confined to her bed but may be allowed to take as much exercise as she is able to, this of course helps keep up the health and courage. There is but little danger in their use, and if the first application does not remove all the diseased tissue, subsequent applications can be made until it is all removed. Frequently when the operation is made with the knife the flaps are drawn forward over a portion of diseased tissue, and the wound heals only to break out again. When the portion to be removed is small, it can be done so easily and with so little show of surgery, as not to alarm the most timid of women, and the patient need not know that she had any cancerous tendency, an object always to be sought for, as most women that believe that they have a cancer, will give up all hope, and run down and die in a short time. It does not take as long to operate with the paste or solution of caustic, as it does with the knife or cautery, and the

shock to the patient's nervous system, from the effects of ether and the operation is avoided. The operation for the removal of either epithelial or scirrhus growths by this method is very simple and easily performed, although much care should be exercised in preventing any damage to the vaginal walls, from the action of the caustics. In a short time the tissue that has been destroyed, sloughs away, and if the growth has all been removed, a healthy granulating surface presents itself, and in a few days heals up entirely. The patient is not debilitated from loss of blood and long confinement in her bed. One great advantage is obtained in using the caustic treatment over all others, and that is almost entire absence of the extremely offensive odors that characterize cancerous growths. The caustic that I prefer is the chloride of zinc either in solution or in the form of a paste. For epithelial cancer I prefer and use a paste applied to the diseased surface. For scirrhus I use a solution that I inject into the growth. I presume that it does not make much difference which of the caustics are used, as the result is nearly the same with them all. The main point is the manner in which it is applied. I have used the bromide of iodine very successfully in one case of epithelioma, where the growth was extensive; for seven years the patient has been perfectly well and is up to the present time. [I had an opportunity to make an examination the last of November.

Dr. Barker gives the details of a case that was cured by the use of acid nitrate of mercury, applied to the uterine cavity. Extensive sloughing was produced, and a final cure resulted. Dr. Emmet says that there is danger of cellulitis and peritonitis in the use of caustics, but I have, after an extensive use of them, never seen the slightest trouble of that kind resulting from their use. The use of the chloride paste is not as painful as is generally supposed. I have removed a whole cervix with scarcely any pain at all.

The constitutional treatment of these cases should by no

means be overlooked. Everything that will tend to build up the patient, good food, out-door exercise and pleasant surrounding should be furnished, and as little reference made to the disease as possible.

The remedies that will aid us, if any have a curative effect, are those that are valuable in all forms of septic conditions. The iodides either singly or in combination have a marked effect, in staying the progress of the disease, in those cases where constitutional symptoms have appeared. In these remedies we shall find more help than has been generally supposed. Chian turpentine, a remedy that has been discarded by nearly all of the profession, has valuable qualities that should not be overlooked, and is worthy of more prominence in the list of cancer remedies than it has at the present day. If it were necessary, I could report many cases in my own practice, and many more that have come under my observation in others' field of labor, that have been cured by this method of treatment, and many that have been given a new lease of life, but it is unnecessary. Any man can gain the same results by resorting to the same means.

UTERINE THERAPEUTICS.—COMPARISON.

BY PHILIP PORTER, M. D., DETROIT.

Murex purpurea.—This secretion, found in the sea-snail in the Mediterranean Sea, is a coloring juice lodged in a bag between the heart and the liver, and is sometimes of a fine red color when taken out, but appears as a tough, viscid, colorless or greenish liquid, gradually reddening when exposed to the air; unlike other animal secretory products, such as apis and lachesis, which act upon the ovaries especially, murex and sepia have a direct affinity for the uterus. Murex and sepia, more than apis and lachesis, disturb the regularity of the menstrual flow.

The sepia patient has late and scanty menstruation, while the murex patient has frequent and profuse menstruation, and as it is usually attended with a strong sexual desire, she is melancholy, sad and indifferent even toward those she loves and members of her own family (*arana diadema*.)

The murex patient is of a nervous temperament ; a lively and affectionate disposition or the opposite condition of melancholy may prevail from the effects of disease, as has been noticed in conjunction with cancer of the uterus, for which murex has been given with good results in some cases. Apis and lachesis both have suppression of the menses with congestion to the head ; and lachesis may sometimes be indicated in scanty menstruation, but mostly after sepia has been previously administered, and when the flow of blood from the vagina produces marked relief. Murex, sepia and lachesis will each produce favorable results in follicular erosion of the os uteri, when indicated by other symptoms ; while apis will have but little influence upon this condition of the cervix. Murex will be indicated when there is a soreness complained of in the region of the cervix, or a feeling as though something were pressing on a sore spot in the pelvis, with pain in the right side of the uterus, going into the abdomen or thorax, with watery, greenish, leucorrhœal discharge that is irritating to the parts, with dragging and relaxation in the perineum, pains in the hips, loins and down the thighs, and great suffering from exertion. The indications for sepia are very similar. It produces the same kind of leucorrhœal discharge, and similar painful sensations in the hips, loins and thighs, but when the menses are early and profuse (*arana diadema*), murex is to be preferred. Lachesis will be indicated in abrasions of the os, when the cervix is very sensitive to touch, bleeds easily ; when there is sensitiveness (no soreness) about the abdomen that renders the contact of the clothing very disagreeable. strong sexual desire with menses regular. (Lyc is often

indicated after lach., and will produce a rapid change in the condition of the abrasion.)

Sepia, murex, apis and lachesis are frequently indicated by the character or location of the pain complained of. The pains of murex are described as sensations of soreness, or there may be stitching pains in the os uteri. The pains of sepia are shooting, stitching and burning in character. Apis has sharp, plunging, stinging, stabbing pains in the uterus, or in the head, sometimes followed by convulsions during the menses (*arana diadema*); pain in the right ovary. Lachesis pain grows gradually worse and worse, until a flow of blood occurs from the vagina, when the pain is relieved; after a while it gradually comes on again, to be again relieved by a similar flow; pains going up into the chest; left ovary affected, with aggravation after sleep.

Under "general concomitants," the symptoms arising during sleep are peculiar, illustrating the special indications for murex, sepia, apis and lach. Dreams: Apis thinks she is flying or making long journeys through the air; thirst; with sepia the dreams are frightful; irresistible drowsiness, but does not go to sleep; awakes in the morning at 3 or 5; drowsy at noon; awakes, thinking she has been called. (This one symptom proved a "lucky stone" for us in treating a chronic uterine case that had baffled the treatment of one of our local practitioners who is regarded as a good prescriber. Every time the lady called upon us she almost always commenced with "Well, I have been called again, every morning, as usual.") Always awakens too early: You will see that none of the apis symptoms have this peculiarity. Murex has awakening early, but with a headache. Sleep prevented by cold extremities; crowding of ideas or nervousness. Sepia and lach. also has some of the early awakening symptoms or nervous sleep, but not so characteristic. Cold feet in bed at night should lead us to think of sepia. Sleep prevented by starting or jumping, lach.—here we again see the different symptom from sepia.

While a *sepia* patient will lie awake from nervousness, a *lach.* patient will be interrupted by startings; restless; cannot sleep, but not from thinking as with *sepia*.

With *murex* "all pains come while lying down, and never go around circumference, but through."

Sepia.—All pains aggravated in the "forenoon and evening"; before falling to sleep; in company; from mental exertion; from music; from washing in water; getting up too soon after confinement is a characteristic symptom; from sexual excesses. Relieved by warm air; solitude; after rising from bed or from a seat; when walking quickly.

Apis.—When the urine is scanty and dark; sexual desires increased. Inflammation of the external and internal organs with stinging pains. Erysipelatous, vesicular or gangrenous eruptions of the labia; œdema of the labia; "burning pains in the coccygeal region, aggravated by any attempt to sit down."

Lach.—In addition to delayed and scanty flow during the menstrual period, there is this peculiarity—all the troubles begin on the left side. She cannot bear anything tight about the throat. This remedy is useful during the climacteric period, and for "young girls who are chlorotic with sickly complexions."

The leucorrhœa of *murex* is thick, bloody or watery, greenish, according to the nature of the pathological condition, whether the disease is acute or subacute in character. There is a return of the discharge during stool; "a feeling of heaviness and enlargement in the labia majora and vagina."

Sepia.—Milky leucorrhœa, only in the day time; a peculiar foetid perspiration, especially from the genital organs, axilla and soles; foetid urine, depositing a reddish, clay-colored sediment, adhering to the bottom and sides of the vessel; sensation as if something would come out of the vagina. (*Lilium* also has this last symptom. With the leucorrhœa there is darting, shooting pains in the region of

the cervix ; occasional contracting pains in rectum, running along perineum ; an empty or gone feeling at pit of the stomach (murex and sulphur).

Apis.—Profuse yellowish or green discharge, with painful and frequent micturition ; acid discharge ; stinging pains through left ovarian region. Dull, heavy pain in region of left kidney.

Lachesis.—More profuse just before menstruation (when congestion of the parts is greatest) ; the discharge is copious, acrid, slimy, green, or thick yellow, and stiffens the clothing and leaves a greenish stain ; there is redness and swelling of the external parts ; smarting at the vulva ; cannot endure any weight or pressure even of her clothing upon the hypogastric regions ; flashes of heat in the day time ; tendency to faint or have an attack of hysteria during or just before menstruation sets in. Despondent and unhappy on first waking in the morning.

EDITORIAL.

The editor, recognizing how poverty-stricken gynæcology is, in therapeutics, and also how essential a more perfect knowledge in drug action in uterine diseases is, we shall, beginning with the first number of this year, inaugurate a system of the study of uterine and ovarian therapeutics. To this end we will commence with the consideration of that fashionable and reputable drug, more used and more abused in the treatment of diseases of women than probably any other remedy in the materia medica, *lilium tigrinum*.

In organizing a system of study of the various drugs more commonly employed by the gynæcologist and general practitioner in ovarian and uterine diseases, we shall, from necessity, be compelled to draw freely upon the profession at large for clinical facts and verification of symptoms already accepted as pathognomonic for the administration of a certain drug. We honestly believe this memorizing method of studying the materia medica is a

faulty one, and sure to place the prescriber in an embarrassing position many times, and yet, until more reliable data are presented, we must to a greater or less extent rely upon the information—only physiological sometimes—we have, although faulty in every respect.

The editor will esteem it a special favor if the subscribers of this journal, or for that matter any physician, will send to him their clinical experience with *lilium tigrinum* in their practice in diseases of women. If all the reports were true of the wonderful effects, curative and otherwise, of this drug, no woman should suffer from uterine or ovarian disease. Let us make a united effort to sift out some of the "trash," and place this truly valuable remedy upon a basis of reliability, so that like sulphur and other old standard drugs we can classify *lil. tig.* and give it the same character and confidence we now do some of the "old timers." The *OBSTETRICAL JOURNAL* will be only too willing to throw open its pages and furnish the avenue through which this work may be accomplished. This work of "sifting" cannot be carried out by one or two, but the entire profession must lend a helping hand. For the sake of uniformity let the report assume something of the following excellent plan adopted by Dr. Minton in his work of "Uterine Therapeutics":

(1) Give name of remedy.

(2) *Menstruation*: Regularity; amount; character of flow. Under this head include every peculiarity of the menstrual discharges.

(3) *Before Menstruation*: Mental symptoms, gastric, uterine, ovarian and general symptoms.

During Menstruation: Same as above.

After Menstruation: Same character of report.

Amenorrhæa: Minute symptoms.

Leucorrhæa: Amount; color and character.

Aggravations: Time; by movement, etc.

Ameliorations.

While the literature in uterine and ovarian therapeutics has been greatly improved within the last few years by such works as Minton's and Eggert's, we still have plenty of room for improvement, and by a systematic course we can exclude many symptoms

that are purely foreign to a respectable consideration of a remedy when selecting it for any given disease, basing the choice upon the result of a proving. We all know that there can not possibly be any sympathy in the choice between the proving of a drug when mechanical conditions are attributed to the action of the drug. Not only in uterine deviations do we see this manifestly brought out, but in other cases of tissue change, when the perverted cell nutrition has been in existence (congenital) in the individual since birth. Do not, therefore, credit *lil. tig.* with having produced ante flexion or retro flexion. Let clinical facts establish the relationship between the drug and the uterine displacements. In considering the treatment of any disease peculiar to women or the proving of a drug, we should always give character to the report by separating that part which is truly mechanical and that which is therapeutical. The two methods are as distinct as possible, and should never be confused. On these two points hangs all there is of the popular question of the day relative to the gynæcological practice in the homœopathic school. All manipulations; the administration of a drug for its dynamo-mechanical effect, like *ergot*, or for its dynamo-chemical effect, like vaginal irrigations of *sodæ biboras* and other well-known salts, should be classified properly and the *therapeutics* of gynæcology given its due credit, and thereby a perfect harmony established between the differences now recognized in every discussion having for its subject some disease of the uterus or ovary.

By a united effort a proper restriction could be placed upon this wholesale work that has to a great extent brought odium upon our therapeutics.

TRANSACTIONS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

BUREAU OF GYNÆCOLOGY—A FATAL CASE OF OVARIOTOMY. BY C. H. HOFFMAN, M. D., PITTSBURGH.—Mrs. Josephine A., *æt.* 39, was admitted to the hospital May 13, 1886. She first noticed an enlargement in the abdomen ten years ago. This gradually increased, until now she is decidedly larger than in pregnancy at full term. For the past two years she has com-

plained of pain in the lumbar and in the pelvic regions. Fluctuation was distinct, and the tumor could be easily mapped out. The tumor filled the abdomen so much that no opinion could be formed as to whether it was adherent or not.

The operation took place May 15, 1886, at 4 P. M. An incision was made from the umbilicus to the pubes, and this was subsequently enlarged to several inches above the umbilicus. The hand was passed as far as possible between the tumor and the abdominal walls, but, owing to the large size of the tumor and the tense condition of the abdominal muscles, this could be done only to a depth of four or five inches.

The presenting tumor was tapped, and another one lying immediately behind the first one was disclosed. Owing to the fact that this second cyst was distinct from the first, almost as far down as the level of the superior strait, it was tapped separately, and then the gravest complications were found.

The upper posterior aspect was widely adherent to the omentum; the descending colon, lying somewhat behind the tumor, was adherent to it for almost the whole of its length, and both were fused with the parietes. The omentum was seared off from the tumor with the actual cautery, but in trying to separate the colon from it the bowel was torn into. Running the hand down toward the pelvis, it was found the tumor was adherent all along the superior strait, and separating these adhesions in one place, they apparently extended universally throughout the pelvis.

The cysts were now cut off low enough to be merged into one, and the walls being thick and vascular, the edges were stitched around with the continued suture, and the edges brought together. The tear in the colon was repaired, and the abdominal incision sewn up.

The wound was dressed in the manner usually pursued in the hospital. Iodoform was sprinkled over the line of the incision, and a compress of antiseptic gauze over this, then three or four strips of adhesive plaster, reaching well around the sides of the patient and thoroughly relaxing any tension on the stitches; over this a pad of cotton held in place snugly by a six-tailed bandage, well drawn up. The patient was under the influence of chloroform for about three hours and a half. When she came out from under the influence of the anæsthetic she felt comfortable, and was very hopeful. Her husband saw her for a few minutes about 10 P. M.

Her pulse and temperature were slightly below normal, and she was given camph. tinct. During the night her pulse and temperature ran up (temperature 102°), and she was given acon. Under this her temperature sank, until next morning it had fallen to 96°. She complained of some thirst. She was given cracked ice

and again put on camph. tinct. Her temperature continued to fall until, at 11 A.M., it stood 94.5°.

There was a great deal of doubt as to the correctness of this reading, so it was verified by two other thermometers.

This subnormal temperature kept up until the morning of the third day, when it rose and registered 99°. Then it sank again, and at 2 P. M. it was 97.6°, rising to 100.4° at 9 P. M. After this it sank steadily until, at 3 P. M. of the fourth day, it was 96.6°. Soon after this she went into profound collapse, and died at 5 P. M.

In the afternoon of the second day she complained of pain in the small of the back, and this gradually became very severe. With the exception of some little pain along the line of the incision and some bloating, she made no other complaint.

Post-mortem at 9 P. M.

The edges of the incision were found to have become adherent. On examining the tear in the colon a leakage was discovered in the lower angle of the wound and a small fæcal extravasation and peritonitis around this. The cysts were somewhat red and injected on their inner surfaces, but no great amount of inflammation seemed to exist. The origin of the tumor was not searched for.

There was some doubt as to what was the best plan to pursue in the management of the cysts when it was found they could not be removed. The anterior cyst could have been included in the incision but to include both, owing to their large size and the thickness of the walls, was impossible.

Had the adhesions to the posterior surface of the hinder cyst been discovered before it was tapped the best plan would very probably have been to let it alone and include the anterior one in the incision and close up the abdomen, but after it was once tapped this was out of the question.

A remarkable thing about the case was the extremely low temperature recorded two days before the patient died, and also the absence of all signs of peritonitis except bloating.

—A CASE OF UTERINE POLYPI—BY R. P. MERCER, M. D., CHES-
TER.—In the month of July, 1873, I was called to attend Mrs. L., aged 38, the mother of six children. She was anæmic and debilitated, suffering from headache, backache, gastric disturbances, uterine pains and hæmorrhage. The hæmorrhage, which had been profuse, was now much less, and the pains lighter. She said she had just had or was about to have a miscarriage.

A digital examination, per vaginam, revealed the os open so that the finger could be easily passed through the cervix into the womb, which was in position and but slightly enlarged. And so

far as could be ascertained, empty. There was still some pain and hæmorrhage with nausea, all of which soon stopped under treatment. The discharges had all been put away, and whether any thing, or what, had been passed could not be ascertained. The history of the case revealed the fact that she had, for several months, been having quite profuse hæmorrhage, with pain, at each return of the menstrual period, which would cease after a day or two, but for the last two or three months had not entirely stopped; it would subside into a slight but constant flow. She had evidently lost much blood, was very weak, and the stomach and digestive organs in a very irritable condition. She had, too, every appearance of being heavily drugged. She had been under *regular* old school treatment, and had taken enough of medicine, as she stated, "to last a lifetime." I doubted her diagnosis of miscarriage, but felt satisfied that whatever might have been the cause of the pain and hæmorrhage, the immediate danger was now over, and at once set about to repair the damage done.

She commenced at once to improve under the carefully selected remedies, and in a few weeks was better than she had been for months before, and in three months was quite well, better than before, she said.

She continued well, grew much stouter, round, plump and plethoric. Her menstrual periods were regular and natural. All the functions of the reproductive organs seemed normal until June, 1878, four years from the time I was first called, when the menses began to show signs of disorder. They would appear at the proper time but the flow was much more profuse and accompanied by pressing or bearing-down pains, slight but well marked. In a week or ten days she was over it, and would remain well until the next month, when the symptoms would again return and pass as before; examination revealed nothing except a slight enlargement of the uterus. The August period passed as the other two, but in September I found the os somewhat dilated, and after considerable effort succeeded in introducing my finger into and through the cervix when it came into contact with something just within the internal os which, although it was firm, I was strongly inclined to believe was a placenta (I had not then had my first case of placenta prævia) and concluded to continue treatment and await developments.

The flow did not entirely stop during this period, but was slight and continuous. The os remained open, there was little pain and her health in other respects was good.

About the middle of October, after a more extended and careful examination, my diagnosis was a polypus with pedicle attached to the side of the uterus about an inch above the internal os, and advised its removal. Surgical aid was called and we removed by

ligature and scissors, a fibrous polypus with short pedicle, the size of a hen's egg.

She was advised that this would be the last of her trouble of this kind, and in a week or two she was well and happy, attending to her household duties, and going where she pleased.

In October, 1881, we removed another of the same character, and preceded by the same train of symptoms as before. This time the tumor had passed down into the cervix and was a third larger. The ecraseur was used and the internal surface of the womb cleared of any and all growths that might remain.

The recovery was rapid, and health remained good until the spring of 1883, when the same train of symptoms again set in.

The tumor grew rapidly and became much larger than either of the preceding, but, as the hæmorrhage was less, I concluded to wait awhile for it to mature.

One evening in the early part of June, I was sent for, the messenger stating that Mrs. L. was in much pain and wished to see me at once. I found her in bed, having strong, labor-like pains, and the vagina filled by a mass as large as a child's head. A turn or two twisted off the attachment and the tumor came away. Laying it to one side and returning my hand into the vagina to ascertain the condition of the womb, I was surprised to encounter another tumor as large as the one I had just taken away (I began to wonder what next), but soon found that it was an inverted uterus that I had to deal with now. The pedicle had been attached at the fundus and it had followed the tumor down into the vagina, causing a complete inversion of the uterus. I now had an opportunity to see the internal surface of the womb, and, bringing it down, I made a careful examination, but could find no sign of any growth or any thing abnormal. It appeared to be in a healthy condition except where the pedicle had been attached, and this had the appearance of having been partly strangulated before it had come away.

Bunching my fingers against the inverted fundus and pressing gently, but firmly, upwards, I found but little difficulty in reducing the womb, it going into a place after a few minutes, with my hand inside. After carefully withdrawing my hand, contractions soon set in, and the organ was gradually brought to its size and place. There was less hæmorrhage this time than before, and the only troublesome symptoms were the irritable condition of the stomach, with nausea and vomiting when any thing was taken, which was soon relieved by the proper remedies, and our patient was around as before.

By September of last year (1885) she had another well-grown tumor, and by the urgent solicitation of would-be friends was induced to apply elsewhere. So my patient passed from under

my care into the hands of the old school, from whence she had come almost twelve years before.

In October last Dr.—— with the assistance of three others and two daily newspaper reporters, removed a fibroid tumor (so they named it at the time) similar in every respect to the others, but less in size than the last one.

After three months of the most approved old school medication, our patient was in a very low, exhausted and starved condition, being unable to retain food or drink or to sleep night or day.

Another operation was urged as a necessity (for what I never heard), and after much cutting, scraping and Listerizing, it was pronounced to be cancer of the womb, and in February she died.

Such is a brief history of this case from the time it came under my care from the old school until she returned and died on their hands, covering a period of nearly twelve years, much of which time she was under treatment with the most carefully selected homœopathic remedies that I was able to find; her general health improved, it is true, but the tumors persistently returned at shorter intervals.

My object in reciting the case here is to call forth a discussion of the following points, which I acknowledge myself unable to answer, or to find answered, viz. :

First—Do uterine fibroids ever become cancerous, that is, do non-malignant growths ever become malignant?

Second—Can a cause for uterine fibroids be given?

Third—Will homœopathic medication relieve, arrest or modify them?

—THE IMPORTANCE OF IMMEDIATE OPERATION FOR LACERATION OF THE PERINEUM. BY I. G. SMEDLEY, M. D., PHILA.—The subject I wish to present to you is by no means a new one, but it is one of great importance to the poor suffering female members of society, that I wish to create among the profession a sentiment favoring an immediate operation for a lacerated perineum; instead of allowing patients either to suffer on through life, or to submit to a secondary operation, the results of which are far inferior to those of the primary.

Before proceeding with our subject, let us briefly review the construction of the perineum, and its physiological functions, so that we can more fully appreciate the importance of our paper.

About half way up the vagina, this passage and the rectum separate, the latter taking a downward and backward course, the former downward and forward in the direction of the pelvic curve. Thus an irregular triangle is created, of which the external perineum is the lever—the posterior vaginal wall and the anterior rec-

tal wall forming the sides. This triangular space, occupied by muscles and their tendinous attachments, vessels and nerves, is the perineal body.

Dissecting off the skin and superficial fascia, we come, midway between the anus and posterior commissure of the vulva, to a highly elastic and dense white tendinous structure, which seems to be made by the fusion of several muscles meeting at this point.

The external sphincter ani, which arises from the os coccyx, surrounds the anus, and is inserted into the perineal body.

Starting at the perineal centre, we find two muscles, some of whose fibres become continuous with the external sphincter, and which pass forward, separate, and pass around the vulvar opening like a fleshy ring, and then converge, each to meet its fellow from the opposite side over the clitoris. These form the constrictor vaginæ muscles—called also the compressor bulbi, and the bulbo-cavernous muscle. The transverse perinei muscles arise from the ascending rami of the ischium, and become united with each other in the perineal body, and also with the sphincter vaginæ, and levator ani muscles. The levator ani muscles, are next in the group in power and importance. They arise from the rami of the pubes, from the spine of the ischium, and from the tendinous bands stretching between these points, and are inserted into the coccyx and the perineal body, and they also interlace with the corresponding muscles of the opposite side; thus constituting the true sphincter of the vagina.

The bulbs of the vestibule and the vulvo-vaginal glands, lie in contact with the constrictor vaginæ muscle, on its under side. By a contraction of these muscles during coition, the flow of blood is impeded, causing a congestion of the erectile organs. The contents of the vulvo-vaginal glands are squeezed out and the clitoris is drawn down upon the male organ.

We see, therefore, that the floor of the female pelvis, is composed of a mass of muscles so interlaced that scarcely one of them has a special property which is not, in a measure, shared by the others. Hence, a loss of any fibre at the point of fusion, entails a corresponding loss of power in the floor of the pelvis, and a consequent impairment to the support of the reproductive organs.

The perineal body fits like a wedge between the rectum and the vagina, thus supporting the anterior wall of the rectum and sustaining the equilibrium of the rectum, vagina, cervix, and the body of the uterus. It also supports the posterior wall of the vagina; upon the posterior wall rests the anterior, upon that the bladder, and against the bladder the uterus, all of which depend largely, for support, upon the perineal body.

Another important function of this body is to preserve the

proper line of projection of the rectal and vesical contents, thus preventing the occurrence of tenesmus which is a frequent cause of pelvic displacements.

The causes of laceration of the perineum, and its preventive treatment, belong more properly to the obstetrical bureau and hence will not be discussed in this paper.

The different varieties of this accident are all so familiar, that it would be useless to mention them here, but there is one form upon which I should like to dwell, and that is what we might call an intra-vaginal tear. This is a tear of the perineal body down to the sphincter ani muscles leaving the external or skin perineum intact. I wish particularly to call attention to this variety of laceration from the fact that it is so liable to be overlooked, and at the same time, neglect of it is attended by results quite as serious as from any of the incomplete varieties. From an external inspection, a tear of this kind could not be discovered, therefore, when examining for laceration, this variety should be borne especially in mind. It becomes an imperative duty always to examine patients, after confinement, for any perineal tear. Perhaps an experienced finger can detect this without the use of the sense of sight, but I always expose the parts to a good light, and carefully wipe them with a cloth, before I can feel satisfied of their exact condition.

The amount of danger resulting from neglect of the laceration will depend upon the degree of the tear. The more extensive the tear, the more severe will be the symptoms, and the sooner will they develop, but sooner or later, in any case, they must develop from a neglected laceration.

The immediate danger is from blood poisoning. This raw surface, with its enlarged and open vessels, over which the discharges from the uterus are obliged to flow, offers an excellent opportunity for the absorption of the diseased germs, which such discharges are apt to contain.

The remote dangers are : rectocele, cystocele, prolapsus and congestion of the uterus, and procidentia, arising from an incomplete tear ; and from a complete tear, the foregoing together with rectal and vesical incontinence.

The final result from the primary operation is far better than from the secondary, although from the latter we may have a union equally as good as that obtained from the former. If a muscle in any other part of the body should be torn across a rational surgeon would immediately set to work to bring the ends of the muscles together in proper apposition, with a hope of getting a primary union ; for if the wound is allowed to granulate with the ends of the muscle separated, the result would be a useless organ. Just so, I claim, it is with these perineal muscles. When

once allowed to heal without proper attention the organ is forever impaired. You must not understand me to say that I do not believe in the secondary operation—far from it. It is the best that can be done under the circumstances, and I know of no operation that will give a patient so much relief as the restoration of this support. For we can apparently restore it—making what is, to all appearances, as nice and firm a perineal body as nature had originally given, but the parts can never be so firm and resisting as though the muscular fibres had been properly united, and if the uterus is enlarged, or there has been a marked cystocele, the constant pressure on this new body will cause them to become absorbed, and the parts will be almost as useless as before.

There are a few cases where the primary operation is contra-indicated; for example, in cases of convulsions, excessive uterine hæmorrhage, excessive exhaustion, advanced organic disorder, mania, etc., etc.

THE OPERATION.

Very frequently the parts are so benumbed by pressure that it causes very little pain to introduce the sutures. If it is attended by much pain, it is best to etherize the patient in order to prevent fright, shock and muscular contraction.

Sponge out the vagina and raw surface carefully with iodine and water, or some other disinfectant, and pack the vagina with two other sponges to prevent the flow of blood upon the raw surface. Control all bleeding vessels by torsion, and the oozing by hot water, and clip off all ragged and irregular edges.

There are many methods for uniting the torn surfaces, but that devised by Simon, of Heidelberg, has been, for me, by far the most successful, except that I substitute cat-gut for the silk which he recommended.

The operation is simply this: A line of interrupted cat-gut sutures is inserted, beginning at the upper angle of the tear, *i. e.*, that part which extends farthest up the vagina, the stitches being just close enough to bring the parts nicely together. This is continued until the external perinæum is reached, after which the skin perinæum should be united in the same way.

In case of a complete tear, the vaginal part should be united down to a level with the rectal rent. Alternate stitches should then be taken in the rectum and vagina until the outer extremity is reached, when the operation is completed as in the former case.

The advantage of cat-gut over silk is that it is difficult to remove the silk from the vagina, while, where cat-gut is used, it may be allowed to remain in the tissue until it is absorbed. I think this method far superior to the wire sutures, for it brings the parts nicely into apposition, without leaving a puckered gaping edge

in the vagina, which allows the discharges to trickle down into the wound, often preventing union. This I have frequently seen occur both in my own operation, and in the hands of skilled gynæcologists, but since using Simon's method I have never had but one failure, and that was in a case where I operated twelve hours after the accident occurred. This was done at the urgent request of the attending physician, but much against my own judgment, for I consider it useless to attempt to get union after a lapse of eight hours.

—MECHANICAL VERSUS MEDICINAL MEASURES IN UTERINE DISPLACEMENTS. BY EMMA T. SCHREINER, M. D., PHILA.—It is not necessary to enter into any argument for or against the use of purely manual or instrumental means of correcting uterine displacements. Such discussions are always one-sided, and only serve to add to the "bone of contention" interposed between the surgeon and physician. Too many of these discussions have been published, to the bewilderment of the student and young practitioner, whose oft-repeated question, "What is truth?" fails of satisfactory answer. Is there not some common ground, where men and women of common sense, the specialist, surgeon, and the advocate of only the *similimum* for "all sorts and conditions" of the human frame, can meet? It would seem that there ought to be. Before prescribing for a mal-position or a mal-location of the uterus, besides taking into account all the symptoms present, it seems necessary to ascertain, if possible, the primary cause of the trouble, it may date years back, and be obscure and difficult to find, but once found, it may prevent much waste of time in bringing about a cure. If the displacement has been caused by violence of any kind, if the chief factor in the displacement has been mechanical, then mechanical measures must enter largely into the curative treatment.

Cases naturally divide into three classes :

I.—The first, requiring chiefly mechanical treatment, is usually made up of acute cases. Patients of this class are most often those in good health otherwise, often robust, active, accustomed to vigorous exercise or hard work. Such persons are liable to over-exert themselves, and by some sudden strain or violent action, a displacement of the uterus is brought about. A jump from a height, a fall down stairs, or being thrown while riding, has caused a displacement which requires manual reduction, quite as much as does any external dislocation, and here medicine is simply an adjuvant.

CASE I.—A girl of seventeen years came to me with severe pain in hypogastrium, back, and groins, nausea and indigestion. Her troubles followed a jump from a fence with a heavy child in her arms. This occurred one week before she came under treatment.

The correction of a retroversion and one prescription of *arnica*^{3*} effected an almost immediate cure. Sometimes a trouble of this kind causes an entirely different train of symptoms, as in the following.

CASE II.—Miss A., æt. 20 years, suddenly began to suffer from extreme depression of spirits, which continued one month, when it amounted to true melancholia. Her mental suffering was terrible to witness. Instead of being the sunny, helpful, sweet-tempered girl of six weeks before, she was morose, gloomy, reserved, seeking solitude, ever mournful, wishing to die. One day when left alone a few minutes, she opened a vein and had lost much blood before being discovered. In health, the most conscientious of beings, she now felt no responsibility for such an act, and only regretted its non-consummation. She had sleepless nights, ate only because of her friends' entreaties, and was beginning to lose her strength. Her previous health had been superb, and even during this attack she was induced to exercise daily, boating, riding, walking, etc. Her menses not appearing at the second month, an internal examination was insisted upon, when there was discovered a left lateral flexion of the uterine cervix. The cervix was bent over like a knuckle, the os much compressed and presenting a narrow line from front to back. The fundus was readily pushed up and kept in place by a tampon of cotton, inserted upon the left side. The patient was directed to lie upon the right side, at night, and several times during the day.

In less than six hours, the cloud seemed to roll off of her mind, and from that time on she was radiantly happy. She seemed to herself, as well as to her family, restored to life. After recovery, she said, in answer to questions, that at the beginning of her misery she did have pain, burning and dragging in the left side; but they went unheeded, because the mental anguish was so overpowering. A sudden wrench received in a gymnasium is considered the cause of the displacement. One week after its reduction she was perfectly well and happy.

II. The second class comprises that great company of suffering women, whose muscular tissues are so undeveloped, or weakened, by artificial restriction, that they form an insufficient protection for internal organs, which, in consequence, perform their functions imperfectly, and become easily deranged. Such slight causes as teaching an organ, lifting a not very heavy weight, reaching to a height, playing lawn tennis, or the pressure of stiff stays and heavy clothing (with or without violent exercise), induce displacements, to which reduction and internal mechanism afford only temporary relief. To effect a sure cure, we need a combination of forces: First, modify the dress to secure perfect freedom of action for all parts of the body. Lightness is important, and if the chest organs

are stronger than the pelvic, let all the clothing be suspended from the shoulders. This done, and the displacement corrected early, we may hope that the indicated remedy, with strict attention to diet, exercise, etc., will insure a cure.

CASE III.—Carrie W., æt. 23 years, for three years suffered from pain and distress of a somewhat varied character, attributed by different physicians to malaria, disease of kidneys, and various other causes. She had been an unusually strong and active girl, doing and enjoying field work usually considered too heavy for women. A year previous to her sickness she had left her salubrious home and taken service as child's nurse in a very malarial district. Her general health suffered from the change; she had not her usual strength, yet, being accustomed to heavy lifting and carrying, tried to continue these feats in her new position. Her sickness was not acute at first, but increased gradually. For three years, she had been under old school treatment, and was constantly growing worse.

Examination showed a prolapse and retroflexion of the uterus, which could be only slightly moved, owing to adhesions and thickening of surrounding tissues from chronic perimetritis. This condition was doubtless secondary to a mechanical dislocation. The patient was much reduced in flesh and suffered from frequent and violent attacks of indigestion.

The hot vaginal douche did good service in this case. The patient was sure it would do her no good, as she had used it before without benefit. Inquiry elicited the fact that it had been taken in a sitting posture. Given, twice daily, with the patient upon her back and the hips elevated, it proved very beneficial. (To provide for the waste water flowing off, the patient was placed, with hips elevated, on the edge of a bed, her feet upon two chairs, between the chairs a bucket, and the rubber sheet covering a pillow under the hips, formed a trough leading into the bucket. In the absence of the siphon bed-pan, this substitute will answer well.)

Water at a temperature of 100° Fahr. was complained of at first, so the douche was begun at blood-heat, and gradually raised to 115°. When the douche was discontinued and the patient first allowed to be upon her feet, she almost demanded a supporter of some kind. The request was not complied with; instead, massage was given, and a regular routine of exercise and rest, with all due attention to dress, etc., insisted upon. The indicated remedy was given at all times, and in one year from coming under treatment, she was so far recovered as to be able to comfortably earn her living.

III. In the third class are placed those women whose uterine derangements are the result of local disease, inflammatory or otherwise, or of a generally debilitated condition. They may

have stood in stores, or have been in constant attendance upon the sick, or have become utterly relaxed from some long illness of their own. The uterus is displaced, sometimes in one direction, sometimes in another. No local treatment is necessary for these last. The positional treatment, by the use of the Moor chair, is a great comfort and aid to relaxed tissues. Very helpful positions may be assumed without this chair, but with it the patient feels that more is being done, and is less anxious for local treatment. Remedies, homœopathically indicated, are here our sheet anchor, as also in all tumors and locally diseased conditions not due to immediate external causes. In the tissue changes following inflammatory affections, local treatment is an important adjuvant, but I believe the conditions requiring it are usually the result of some external influence. The indications for many of the operations in vogue may also be determined by the cause of the condition. When prolapse of vaginal walls and adjacent organs has been caused by difficult labor and premature "getting up," the patient being healthy, the best results from operation may be anticipated. But in very much the same condition, when the cause is *disease or general debility*, better results may be secured by the same period of enforced rest and medical attention which the operation would necessitate, without any surgical interference whatever.

CASE IV.—Mrs. L. (widow), æt. 41, had always been delicate ; was of a highly intellectual and emotional nature ; had nursed her husband and her father in tedious illnesses, terminating with death ; was constantly anxious about her own and her children's health. The patient came to me for "falling of the womb." Examination revealed a very roomy pelvis, with an utterly lax condition of all the soft parts. She had worn various supporters, each one of which had caused leucorrhœa and pain. The uterus changed its place with every change in the patient's position, and she refused to stand erect without a cotton tampon or support of some kind.

Treatment was directed toward energizing and toning up her system, and her first walk without a supporter was taken while under the impression that she was still wearing one. This walk was so much enjoyed that no further trouble ensued from pessaries. Much comfort and actual benefit was derived from the use of Dr. Moor's chair, and from abdominal respiration, regularly practiced in loose clothing, which allowed the retentive power of the abdomen to be fully exercised. This patient will always be delicate ; she probably would not be happy otherwise ; but her attention is not drawn to her uterus any more than to other organs, and she is not injuring herself with pessaries. The homœopathic remedy always gives her sufferings prompt relief, and she enjoys life well.

—STERILITY.—By HARRIET J. SARTAIN, M. D., Phila.—The subject of sterility is one that should command the attention of the general practitioner, as well as of the gynæcologist. Although quite uncommon among the ancients, it is now stated by Sims and other authorities, as summed up by Edwin M. Hale, M. D., in his work on sterility, that about every eighth marriage is sterile. This is not only in our own country, but in foreign countries also. Whether or not this increase is due to a more luxurious mode of living than in the past, including highly seasoned foods and stimulating drinks, over-heated rooms and lack of out door exercise, the fact still remains.

One might judge from the children that fill the courts and alleys, among the hard worked, poorly clad and ill fed part of our population, that such might be the case, but it is of the higher classes where people desire children and do not have them, and where their advent would be hailed with delight, and the world would be better for their being born, that I propose to speak.

Simple stenosis of the os uteri and os internum, without disease, is very frequently met with. Dilatation is its cure, but dilatation in careless hands often produces bad results. Not wishing to injure the cervical tissues, I do not dilate under ether, but let the patient govern the amount, by what she can bear without *severe pain*, preferring gradual dilatation to the rapid and forcible method now so much the fashion. In simple cases, I use T. G. Thomas' dilator, with which you are all familiar; in those more serious, Molesworth's; beginning one week after the menses cease and repeating twice a week, making four times before the return of the period. In many cases it is all that is necessary. If the menses return after the second period, I again repeat the treatment.

A lady in perfect health, who had been married many years without children, consulted me as to the reason. I could discover nothing, but remarked the os might be a little larger and it will do no harm to dilate it, and did so. It was the day before the period, but the menses did not appear, and the one dilatation was followed by conception.

Stenosis with cervicitis requires the same process of dilatation with local applications. For simple inflammation, an application of carbolic acid one part and glycerine ten parts, is stimulating and cleansing, and serves a good purpose. If there is erosion or laceration, fluid ext. hamamelis or hydrastis canadensis, or if an old and deep-seated ulceration, sulphate of copper or boracic acid, with appropriate internal remedies. Those I have found most efficacious, are: *actea*, *apis*, *bell.*, *kreosotum*, *lachesis*, *merc.*, and *sepia*. Endometritis should be treated by dilatation and the same local applications as cervicitis, applied by wrapping a mop of absorbent cotton around the end of the forceps and claspings it, so as not to lose it within the cavity.

If a bland, thick leucorrhœa issues from the os, with pain in the back and head, and great depression of spirits, *actea*. If the discharge is acrid, and irritating to the mucous surfaces, *kreosote*. Discharge profuse, greenish-yellow and offensive, *merc. viv.* If the uterus is enlarged and indurated, a speedy reduction can be brought about by a pledget of cotton saturated with carbolic acid and glycerine, once in three or four days; if exhausting to the patient use *hydrastis* and glycerine instead, with *actea* three times a day. After the removal of the cotton, which should be retained about twenty-four hours, or as long as the watery discharge it causes continues, an enema of one part milk and two of water, daily, until the next treatment, is very soothing and healing. *Cosmoline*, applied by the patient herself, is sometimes preferred. *Vaginitis* requires the same local applications and the internal remedies that are indicated by the character of the discharge. *Ovaritis* should be treated by the indicated remedies. While our text books give *apis* for the right ovary, I have found it more useful for the left. I have often cured an irritation of the left ovary of long standing, with *apis* alone. I change the potency instead of the remedy in affections of the left ovary, until fully satisfied *apis* will not do the work. Next in value for the left is *lachesis*. For the right, *belladonna* and *apis*; and for either, if indurated with constant burning pain, *ars. iodatum*. The potencies I prefer are the 3d, 30th and 300th.

Sterility depending on congestion induced by different measures for preventing conception is most difficult to cure. The vitality of the tissues is so impaired that any slight abrasion soon becomes a deep ulceration, with a muco-purulent discharge. The general system is very much affected, also the nervous. Pain in the top of the head and down the spine, particularly in the sacral region, and depression of spirits usually attend such cases.

The semi-weekly application of cotton saturated with carbolic acid and glycerine, and *actea*, three times a day, for some weeks, combined with proper hygienic measures, will slowly bring about a radical change, and with a good constitution sometimes a cure. Sterility may be brought about by criminal abortion frequently repeated, and though the patient seems to recover her tone, she remains sterile, while abortions due to other causes, are curable and followed by offspring. Women often are childless, and the subjects of repeated abortion from specific disease in the husband.

In failing to cure such cases our skill is often questioned, but it is to the credit of the profession that its members keep silent, when speaking would destroy the happiness of their patients. It may seem a happiness built on a poor foundation, but if under the circumstances it is the best attainable, it should be saved when

possible. Sterility is sometimes due to polypi, either fibrous or vascular, that act as mechanical obstructions. The treatment is their removal, accompanied by such remedies as *calcarea carb.*, *staphysagria*, *teucrium* and *sulphur*.

Cervical laceration sufficient to cause sterility requires a surgical operation. That I need not describe as you are all familiar with it, and if not, it is fully laid down in our text books.

For sterility depending on mal-positions, repositing the organ and supporting with sponge or cotton and internal remedies as indicated. *Lilium*, *nux vom.* and *sepia*. For flexions, similar treatment combined with dilatation. Imperfect development of the uterus is often met with. I have examined cases in well developed women above the ordinary size, where the uterine cavity would not measure over one and a half inches, and the os and cervix would only allow the passage of the smallest French bougie, and that after several attempts.

Repeated dilatation has been followed by conception, and full grown children have been born at term without injury to the mother. In one case so treated, a well developed child died shortly after birth, and the mother two hours later, apparently from exhaustion; as the attending physician told me he could find no other cause for her death. She was perfectly well during her pregnancy, which terminated in a natural labor.

I know it is considered necessary, by some authors, to try to develop the uterus by electricity, tents of different kinds, and remedies for conception, but in my experience, pregnancy has proved the best and safest developer.

Vaginal atresia, congenital or acquired, needs a surgical operation. A case following severe inflammation and severe caustic treatment, on which I operated, was followed in less than a year by the birth of a healthy child at full term.

Sterility following peritonitis or pelvic cellulitis after labor, is cured by the treatment and remedies that cure ordinary inflammation, congestion and induration. I have spoken of cases that are amenable to treatment, and have avoided such as are absolutely sterile, from absence of the uterus or ovaries or both, or diseases that destroy the vitality of the tissues, as in such cases all interference is useless.

—**DYSMENORRHŒA.**—BY THE BËNNINGHAUSEN CLUB, Phila.
—Dysmenorrhœa, as the name implies, means painful and difficult menstruation. A disease which is apparently much on the increase, due, no doubt, to many causes. This disease has been referred to five different conditions, hence we will have to recognize five different kinds of dysmenorrhœa, namely:

First; Mechanical or obstructive dysmenorrhœa;

- Second ; Congestive or inflammatory ;
- Third ; Neuralgic, sympathetic or spasmodic ;
- Fourth ; Membranous ;
- Fifth ; Ovarian Dysmenorrhœa.

The first named, mechanical or obstructive form, is no doubt the most common of any of the above-named forms. It is claimed by some physicians that dysmenorrhœa cannot exist without some mechanical or obstructive means to the flow of the menstrual fluid from the uterus. There are various opinions as to this claim, as well as to where the seat of the obstruction is generally located. There is but little doubt but what it is usually situated in the uterus, but it may be and sometimes is in the vagina. Some writers think it to be generally in the os tincæ, either the external or internal ; in either of these cases the physician is apt to find a conical cervix. A false membrane sometimes grows in the cervical canal and causes an obstruction ; clots of blood or viscid mucus may cause an actual obstruction. Uterine polypi and fibroid or other tumors may cause obstruction to the flow, and hence very severe cases of dysmenorrhœa.

Flexions form an important part in many cases, perhaps in the majority of cases. Flexions, to cause dysmenorrhœa, must be quite acute, for the obstruction in such cases is caused by the cervix uteri being flattened, bringing the walls so closely together as to retard or stop the flow of the menstrual fluid.

That the external os of the uterus is occasionally so small as to cause an obstruction cannot be doubted, for it has been proved beyond a doubt. This cause may be congenital or secondary. It is often the result of application, to the membrane of the cervix, with nitrate of silver, or some other powerful caustic ; but we have no records to show that there are a great many cases, where the obstruction is at the external os, and still less cases are reported where the obstruction has been found to be at the internal os of the uterus.

Retroflexion is, no doubt, the most common and severe, as the angle of flexion is much more severe than in any of the other recognized forms of flexion. Although a pin-hole channel through the cervix uteri has been known to permit of a fatal hæmorrhage, we are led to infer from this that if the menstrual fluid is in a perfectly normal condition, that it will pass through a very narrow channel without causing dysmenorrhœa. There are several reasons for believing that the obstruction is not always in the genital passage for the menstrual fluid, for instead of the homogeneous nature of the menstrual discharge, blood, mucus and the molecularly disintegrated decidua, there are often clots of blood, masses of viscid mucus, fragments of the inner surface of the uterus, etc., which clog up or obstruct the menstrual flow, and give rise to

severe cases of dysmenorrhœa. This obstruction, or common form of dysmenorrhœa, is often accompanied by inflammation or congestion of the body of the uterus, as well as an inflammation and abrasion of the lining membrane of the cervix ; that these complications contribute to the cause of pain with the obstruction present cannot be doubted. It should be borne in mind that not all cases of dysmenorrhœa are constitutional, but that there are many incidental causes which might be mentioned, such as arise from wearing tight-laced corsets, high-heeled shoes, over-fatigue from long walks, standing for hours upon stone floors without resting the uterine ligaments, dancing, jumping from high objects upon the floor or hard ground, lifting and carrying heavy burdens, catching cold at the menstrual epoch, shocks to the nervous system, whether it be from fear, grief or joy, or remaining in the water too long when bathing, not unfrequent after the new relations incident to marriage. Inflammations and ulcerations ; ulcerations in the virgin state, may be a cause. Ulceration following inflammation of the cervix, is quite a common cause of dysmenorrhœa.

This mechanical or obstructive dysmenorrhœa is apt to afflict old maids more than married ladies. In fact a cure usually follows childbirth.

The symptoms of this form of dysmenorrhœa are various and differ in intensity, being mild in some cases and very severe in others. The pains usually commence in the pelvis and radiate to the groins, sacrum and thighs. The hypogastrium and groins are usually very sensitive and tender ; in many cases the whole trunk seems to share the aches and pains. The pains may make their appearance a little before, with or soon after the appearance of the menstrual discharge, and they may cease with or soon after the same, or they may continue, more or less severe, during the whole menstrual epoch. With the paroxysmal pains we may find vomiting, headache, hysteria, delirium, and even convulsions.

The menstrual flow may be scanty or profuse ; in either case it is apt to be followed by a yellowish discharge for several days after the flow stops, this to be followed by a leucorrhœal discharge throughout the entire inter-menstrual interval.

Second.—*Congestive or inflammatory dysmenorrhœa* is the name given to those cases where the uterus is congested or inflamed, causing it to be much heavier than natural. This form is found more in the married than in the single ; in fact it is quite rare to find a case of inflammation of an unimpregnated uterus, and when such is the case, it is usually caused by the obstruction which has been at work for months, and perhaps years, before the inflammation began. It is found particularly in women of full habit and sanguine temperament ; young girls with florid complexion and

plethoric habits, before the menstruation is fully established. It may be caused by exposure to wet or cold, may be in consequence of exciting or depressing mental emotions. Displacements of uterus, sub-involution of uterus, following labor, may cause it ; in fact, anything that tends to keep an hyperæmia in the uterine vessels, and cause pressure on the neighboring tissues, will cause congestive or inflammatory dysmenorrhœa. The symptoms of this form are similar to those of mechanical or obstructive dysmenorrhœa.

Third. *Neuralgic, Sympathetic or Spasmodic Dysmenorrhœa.*—This form is less common than either of the former mentioned varieties, yet at one time it embraced many cases which came under notice, but since more efficient means have been employed for learning the condition of the uterus, the number in the category of cases has greatly diminished. At present it is limited to cases in young girls, to whom it is not desirable to make a vaginal examination, and to those cases where no pelvic lesion can be found to account for the suffering. Some physicians say there can be no neuralgia of the uterus, but that cannot be very well doubted, yet cases of this kind are rare, and it takes no little care to correctly diagnose a case of this kind. This form of dysmenorrhœa may be said to show itself more in ladies of a neuralgic or rheumatic diathesis, and who are subject to neuralgic pains in other parts and organs of the body. It may be due to plethora, or the opposite condition—chlorosis ; gouty patients are apt to have it. It may be caused by excessive sexual intercourse, or by masturbation. The pains are spasmodic in their nature, and often of the most distressing character, lasting for hours, and sometimes for days. They simulate the pains of labor, and they are equally if not more agonizing, the pains being more steady. In fact sometimes they are continuous, running to the small of the back, down the lower limbs, into the sacrum and hips, into the iliac and hypogastric regions, with frequent inclinations to urinate from the sensation of weight, fullness, and bearing down feeling in vulva, perineum, rectum and coccyx. Usually, after the menstrual flow is established, the pains and spasms moderate or cease altogether. This form of dysmenorrhœa is, taken altogether, a very severe and distressing condition for a patient to get in, and one which taxes the physician's skill to cure.

Fourth. *Membranous Dysmenorrhœa.*—This is the name applied to cases where there is a distinct membranous cast thrown off at the menstrual epoch (which, if not carefully noticed, might be taken for the product of conception). In these cases, the mucous lining of the uterus seems to be much thicker in structure than natural, but this cast is identical in structure with the lining of the body of the uterus, it contains glands, bloodvessels, and is

in fact the decidua ; when it is thrown off it does not, under ordinary circumstances, break down into impalpable shreds. It may come away whole or in parts, when it is expelled whole the pains and spasms are severe, almost like labor pains. The pathology of this distressing form of dysmenorrhœa is not understood.

Fifth and last. *Ovarian Dysmenorrhœa*.—This last form we have to consider barely deserves the name of dysmenorrhœa, for it is not due to menstruation ; that is to the discharge of the sanguinous fluid from the uterus, but to the growth and rupture of the Graaffian follicles of the stroma or surface of the ovary and the extension of inflammation to the surrounding tissues. It is mostly always of a secondary nature, rarely if ever primary, found mostly in ladies who have had children, and is often the consequence of an abortion. In the unmarried, it is quite rare ; when found in the unmarried it is due to violence, or to true dysmenorrhœa primarily, and ovaritis secondarily ; exposure to wet and cold about the time of the menstrual flow, severe injuries on the abdomen, over the ovaries may be causes. The pains are different from the other forms of dysmenorrhœa I have mentioned. It is by no means a sudden process as the Graafian follicle usually ripens and ruptures several days before it is thrown off in the menstrual discharge, and sometimes it is thrown off after the flow ceases, perhaps several days after. The pains generally come on several days before the catamenia and may cease with the appearance of the menses, or they may cease several days before that event. The suffering may begin with the flow or during the interval. It is usually situated in the left ovarian region, as the left ovary is the one most apt to be affected, due, perhaps, to the irritation caused by constipation, etc., in the descending colon ; the pains extend down the hips and thighs into the sacro iliac joint of the affected side, with a tender kidney on that side. Patients will often complain of swelling on the affected side, and upon examining the side a diffused fullness is found in the ovarian region which is usually tympanitic, and due, evidently, to local distention of the intestine by gas. Examination per vaginam or per rectum will often detect a small tumor, tender, movable in the early period of the disease ; later on more firm ; it is usually a little behind the uterus. Pressure on this tumor produces severe pain and sickness. Later on, the uterus becomes less movable and drawn to the affected side, due to contraction of inflammatory products, and not to distention of the broad ligaments, for it occurs in cases of long standing. In these cases, the bladder usually becomes very irritable, causing frequent micturition, which is often very painful.

JOS. HANCOCK, M. D.

—TREATMENT OF DYSMENORRHŒA.—Although dysmenorrhœa is only a symptom, it is such a painful one that it compels special attention to means for alleviation and cure.

While most cases respond to the well selected remedy, others yield only to operative measures ; or the patient though assured of final relief from her pains, becomes impatient and wishes some more speedy way out of her troubles.

In the treatment of this painful condition, too many are apt to rely, almost entirely, upon subjective symptoms rather than objective ones, while there is no ill of female life which requires more thorough investigation as to its cause.

Obstructive dysmenorrhœa may be due to polypi which must be removed, flexions which need to be corrected, displacements which require replacing, stenosis of the cervix, which must be made round, pin hole to be enlarged, which may yield to such operative procedures as may be necessary to overcome the mechanical obstruction.

It is strongly urged in cases where time is of small moment, to dilate the cervix, by the continued use of tents, either sponge, tupelo, or laminaria, gradually increasing the size until sufficient has been obtained. Other recommend the use of graduated uterine bougies.

Goodell, of this city, speaks most highly of rapid dilatation, under ether, and recounts three hundred and twenty-four cases treated with the most favorable results. Molesworth's dilator may be used to advantage, when the amount of dilatation is not great.

If the dysmenorrhœa is due to elongated cervix, or narrowing of the cervical canal, dilatation by one of the methods named, slowly with tents, though this has possible danger from septicæmia, or more rapidly by bougies, or Molesworth's dilator, or still more rapidly and at one sitting, under an anæsthetic, by the use of a strong steel dilator, stretching the uterine canal, from one half to one inch. There is very little danger from tearing the cervix, though there are a few cases on record. The relief obtained, in a large majority of cases, is most marked.

Septic influences may be avoided, or much lessened by the use of proper antiseptics, carbolic acid, corrosive sublimate, merc. bin. iod., etc., the vagina being thoroughly washed out before the operation, either with a soft sponge or prepared cotton, dipped in the antiseptic solution.

Too great care, on the part of the operator in regard to personal cleanliness, cannot be taken. The hands should be well washed with warm water and soap, using a nail brush to cleanse the nails. Many an obscure case of sepsis, both in gynæcological and obstetrical practice may be traced to lack of care on the part of the medical attendant.

Dysmenorrhœa dependent upon a depressed state of the nervous system requires rest, proper medicine, and change of air.

The congestive variety may be treated by exhibiting the indicated remedy, the use of hot fomentations to the abdomen, sitz baths, quiet, and rest in bed.

Ovarian dysmenorrhœa is best treated by the remedy homœopathically indicated. Membranous dysmenorrhœa yields to the wisely selected remedy.

Too much cannot be urged against the use of opiates to lull the pain, for while the patient is easier, the results are most pernicious.

GEORGE T. PARKE, M. D.

BOSTON GYNÆCOLOGICAL CLUB.

The Boston Gynæcological Club at its last meeting adopted a programme which called for two or more clinical cases to be reported by each member. The history and symptoms both subjective and objective were to be carefully and clearly presented; then each member present was to write his diagnosis and prescription for the case as presented and read this and defend it if criticised or questioned.

The plan though imperfectly followed proved very satisfactory and interesting to all present, and will be continued at the next and other future meetings in a manner, we trust, to afford a more valuable report, and to develop a better knowledge of our therapeutic resources.

The first case was described by Dr. Robt. Hall, as follows :

Mrs. M——, 33 years of age, married sixteen years, has one child fourteen years old, which was born at seven months. She suffered for about four years from female troubles after the birth of her child. A short time after her recovery from the above sickness she had inflammation of bowels as she says, which lasted about two month. Was healthy from childhood up to the time of her confinement. She matured at thirteen, menstruation continuing regular, but quite profuse to the commencement of gestation. After her recovery from her last sickness, she maintained good health for a period of eight or nine years. I was called to see her the first time, the 22nd March, 1886. At which time she was suffering from pelvic pains extending to left inguinal region, accompanied with almost constant uterine hæmorrhage; at times quite profuse. I attended her from this to the first of July following.

Since the last date she says she was *well* and menstruated normally to October 3rd. At this time she says she took cold during an evening ride in a horse-car. At which time she experienced

slight chills, soon followed by pain in the pelvic and left inguinal regions, and extending down the left crural nerve.

At this time I was called to see her, and found her lying on the lounge, quite feverish, and suffering as above stated. Vaginal examination revealed the following condition: The pelvic cavity seemed filled with a hard, tender and unyielding mass, with the uterus occupying a central position, and thoroughly fixed. This hard and tender mass could be felt by conjoined manual manipulation to reach above the superior strait, higher on the left than right.

The pain continued severely for about three weeks, with a marked degree of fever, anorexia, inaction of bowels, etc. At about this time the pain ceased almost entirely, febrile symptoms gradually declined, and the general organic functions have gradually resumed their normal condition. She now sits up several hours a day and walks around the floors on which she lives.

Diagnosis and prescriptions were to be made for the conditions described at the time Dr. Hall was called in, October 3d, and I report as nearly as I can in brief the opinions and prescriptions offered.

Dr. W. H. Lougee. Diagnosis: Pelvic cellulitis. Treatment: Bell. and thuja, hot water injections and an opiate, if pain is severe.

Dr. J. K. Warren. Pelvic cellulitis. Treatment: Puls. and merc. biniod. Tampons saturated with glycerine and bell., also hot water injections.

Dr. G. R. Southwick. Pelvic peritonitis. Treatment: Xanthox. Hot water douches and hot applications externally.

Dr. G. H. Payne. Pelvic cellulitis. Treatment: Bell. and merc. protoiod., and later kali iod., if suppuration occurred. Glyceroles of bell., and later of iodine.

Dr. L. A. Phillips. Diagnosis: Pelvic cellulitis. Treatment: Acon. tinct. drop doses every hour at the outset, and merc. protoiod 3x every three hours. Hot water douches frequent and profuse.

Dr. Hall's report was then completed as follows:

Diagnosis: Cellulitis with metritis. Treatment: Perfect rest in bed. Vaginal injections of hot water. Morphine in quantity sufficient to relieve pain. Bell. 2x and aco. 2x in alternation for the acute stage, followed later by mercurius, china, ferrum, iodine, sulph., etc. Prognosis: Uncertain.

In the discussion which followed, Dr. Southwick claimed that only after recent parturition had post-mortem evidences been found of *cellulitis*, and that this very rarely and probably never existed under other conditions such as described in Dr. Hall's

case, and he cited several authorities, among them Hart and Barbour, Shroeder and Thomas as sustaining him in his diagnosis.

The arguments in support of the diagnosis of cellulitis offered by others were that pain was less intense than in p.; pelvic organs more fixed; pulse less rapid. Course *long* in c.; *short* in p. Pus forms in 48 hours in p., and generally not before 14th day in c. Post-mortem evidences not proof, as cellulitis is rarely fatal, hence furnishes no such evidences. The prescriptions were generally defended by the personal experience of the prescribers and a consideration of the pathological conditions.

Dr. Southwick however prescribed xanth. because of the characteristic pain in inguinal region and extending down along the course of the crural nerve. He believed it to be the *homœopathic* remedy. Its applicability to the case was doubted by others, as the pain resulting from xanth. provings was not from inflammatory action and consequent mechanical pressure upon the nerves involved, as is the case in cellulitis, etc., etc.

There was but little time left for other reports; but Dr. Payne read two interesting cases which are appended, and which most of the members preferred not to venture an opinion upon without personal examination.

Case No. 1.—Mrs. W. aged about 32 years, a tall, slim, light complexioned lady consulted me in regard to a trouble she had in the left side. Upon examination I found an enlargement about the size of a child's head at full term. It was in the left inguinal region and extended nearly up to the crest of the ilium. It was very hard and unyielding to the touch. By an examination per vaginam I found that it filled the vagina near full. Owing to the extreme tenderness of the uterus I have never been able to introduce a sound, and only know of the size of the organ by external examination. There was no heat or tenderness about the vagina and no discharge. The patient menstruated regularly every twenty-eight days, and has had no hæmorrhages; twice when she has overexerted herself she has had a protracted flow, but not serious. The history of the case is very obscure, all I could learn was that she had been very sick in the spring with what I concluded was pelvic cellulitis; she did not know that she had any trouble before that.

Whatever the trouble was it was an enlargement of the uterus and my diagnosis was a fibroid enlargement.

The treatment has been since she came into my hands since last July local applications of fld. ext. of belladonna and glycerine and iodine comp. and glycerine twice a week. Internally she has had a one grain ergotine morning and night. At this time the uterus is about the size of a medium sized orange.

Case No. 2.—Mrs. W., aged 26, about 5 feet high, a blonde, con-

sulted me last September. The history of the case is substantially as follows : about two years ago had an enlargement in right ovarian region, it was hard and quite painful, which reduced her general health very much. About one year and a half ago she was taken to a hospital and an operation was attempted and not completed, the reason being given as she tells me that she was too low and they could not keep her under ether long enough to complete it. At the time I first saw her there was a discharge from a point in the abdominal incision where a drainage tube had been inserted, and also where one had been placed in the vagina. In addition to the above trouble was another enlargement on the opposite side which was larger than if she was ready to be confined. This enlargement showed distinct signs of fluctuation. This side I diagnosed as an ovarian cyst and I subsequently took away two quarts of ovarian fluid with an aspirator. The patient had not menstruated for over two years, and is in very delicate health.

Case described by J. K. Warren M. D.—Mrs. H., aged thirty-eight years. Twenty years ago gave birth to a child at full term, was perfectly well as far as she knew all the time she was carrying the child, had rather a long tedious labor, otherwise it was normal, but had a poor getting up ; had one thing after another until general dropsy set in. She was considered very sick for many weeks and did not fully recover for about a year. Some eight or ten years later she again became pregnant and was sick from the very first ; the anasarca appeared early and increased as the time advanced and during the last two months she was considered a hopeless case. At the end of nine months she was delivered of a female child. The labor was normal but the recovery was very slow and tedious as before. From that time to three years ago last summer, the date of my first visit, she has had some form of uterine trouble and had been told she must never have any more children. Three years ago last summer I was called to treat her for a severe case of cellulitis and peritonitis, the exciting cause for which I never could determine. There was a great deal of gastric disturbance and extensive inflammation throughout the pelvic cavity, there was no abscess formed, at least no pus discharged ; uterus was forced low down and firmly fixed where it has since remained, although it is a little more movable than at the time of sickness. She has been comparatively well during the last three years except whenever she has been on her feet a good deal or overdone in any way ; then she would have pain and soreness in the pelvic region ; menses have been pretty regular until the last of November when they failed to appear, and have not come on since, otherwise she is well. Is she pregnant, and if so what is my duty ?

Diagnosis : Pregnancy. Treatment : Advised waiting and let nature take its course.

The case presented by Dr. Warren was not much discussed for want of time ; but it was thought doubtful if the woman was pregnant, and even if she should prove to be so it was advised that nature should be allowed to take her course. Further reports were postponed till the next meeting.

L. A. PHILLIPS, M. D., Secy.

SOCIETY NOTES.

—TRANSACTIONS OF THE BUFFALO OBSTETRICAL SOCIETY.—
Dr. P. W. Van Peyma read a paper entitled, "Some Points in the Use of the Obstetrical Forceps." After referring to the dread with which the text-books had inspired him, as a student, to regard the forceps, and a somewhat humorous recital of his first experience with the instrument, he stated that the main object of the paper was to emphasize his strong belief in the usefulness and harmlessness of the forceps, when employed with the most ordinary prudence and common sense, in many cases where nature may be capable to effect a delivery unaided, but after hours of additional suffering, and with increased danger to both mother and child. He then stated that this opinion was based upon an experience extending through a practice of more than ten years, and embracing an attendance upon a total of more than 650 cases of obstetrics. Of these, the larger majority were cases presenting some abnormal conditions, and fully 300 were midwife cases.

For years the number of midwife and other abnormal cases had far exceeded the number of those where the writer was in attendance from the beginning of labor, or where the progress was normal. In fact, the cases not originally attend by midwives were, with very few exceptions, either primiparæ, or women who, for some reason—perhaps previous experience of difficult labor—desired the attendance of a physician throughout.

The 300 midwife cases, with others occurring in his own practice and that of other physicians, included at least 150 forceps deliveries. The abnormal conditions existing in these cases, and requiring the use of the forceps, were complete or partial cessation of labor pains, rigid os uteri, malpositions, convulsions, face presentations, after-coming head, prolapsus of the funis, deformed pelvis, monstrosities, and placenta præviæ.

It should be remembered, said he, that some midwives attended, yearly, as many as 200 to 250 cases ; and taking the practice of half-a-dozen of these midwives for ten years, would give an aggre-

gate of from 12,000 to 15,000 births. A physician, therefore, who was the exclusive consultant for those six midwives, could claim to have seen the abnormal cases of at least 10,000 confinements. He strongly emphasized the difference between this and an ordinary obstetric practice, since it was often overlooked and rarely appreciated.

In connection with the well known rules for applying the forceps, he would only call attention to a very important and much neglected injunction, viz., to be sure that the blades of the instrument passed within the rim of the uterine mouth. The point was then made that the application of the forceps does not imply the employment of force. The large majority of forceps deliveries were stated to be in consequence of a want of the normal vis-a-tergo, and the writer asked, "Why should we hurry in these cases?" The forceps had furnished the complement of force, sufficient traction having been added to make the combined forces equal to the normal. The initiatory traction having started the head, it is frequently unnecessary to pursue it further, the normal uterine contractions having thereby been set to work to some purpose. Yet, even in such cases, he considered it unobjectionable to allow the forceps to remain *in situ* until the end of the second stage, and that earlier removal was useless, since the instrument might be required at a later period.

The commonly accepted view that there was no danger to the child during the first stage was believed to be erroneous, for he had seen the head engage and become exceedingly compressed during this stage, the uterine walls preceding the head, and becoming likewise injured. An instance was cited in which the child was alive two hours before the termination of labor, and yet, though the second stage lasted but an hour, the child was born dead. In the case of this woman the first stage usually lasted a week, but, by artificial dilatation of the os and the application of the forceps, he had been able, subsequently, to deliver her twice of living and healthy offspring, beside saving her days of suffering.

In cases of natural head presentation, with too early rupture of the membranes and draining away of the amniotic fluid, he believed the os should be dilated and the forceps applied, delay being dangerous through pressure of the uterine walls upon the child and cord. But in all such instances, deliberation and patience were necessary, and sufficient time should be allowed for the head to become elongated by gradual pressure. The amount of traction force was, in some cases, enormous; though these were rare exceptions. Slipping of the forceps should be exceedingly rare. Bringing the handles forward too rapidly was believed to be a frequent cause of slipping, and should therefore be avoided.

A motion from side to side, and from before backward and the reverse, during traction, was, within certain limitations, considered useful, notwithstanding the objection in principle that any lateral swinging must increase, temporarily, the transverse diameter. This increase, however, he declared to be absolutely insignificant, while, by means of leverage, a far less amount of direct traction was required, thus making the delivery not alone much easier to the accoucheur, but also diminishing the pressure upon the maternal soft parts, and the scalp of the child.

In cases where the forceps could not be made to lock easily, he advised tentative traction until the head came down somewhat, or at least changed its position, when the instrument could be regularly applied; also, in cases where a tendency to twist was apparent, locking the forceps having been already accomplished.

Regulating the line of expulsion by positioning the pelvis of the mother during the successive stages of delivery, was a manoeuvre which he thought would materially assist the operator, particularly in cases of projecting sacral promontory. The recognition of slight deformities and the consequent need of the forceps was difficult; and the simple fact that labor was retarded in an otherwise apparently normal case, he considered a safe guide to its use. In false presentations, where the head did not fully engage, and the uterus was not too firmly contracted, he believed version to be much the more preferable operation, but stated that, with the woman in the knee-chest position, the vertex might sometimes be brought down, and the forceps applied to hold it in its new position.

Regarding the treatment of the after-coming head in either anterior or posterior positions, he strongly advised the use of the forceps if there was more than two minutes' delay in delivery. An exception to this rule was illustrated by a case in which twisting of the neck had taken place, the chin catching on the pubes; but as soon as the chin had been rotated posteriorly by the finger introduced into the vagina, the head was spontaneously delivered. Finally, in cases of prolapsus of the funis, the head not having engaged, he had found it very useful, after repositing, with the woman in the knee-chest position, to apply the forceps and retain the head, until a few pains had forced it into the grasp of the cervix.

DISCUSSION.

Dr. Milan Baker, in opening the discussion, said that while the forceps occupied a very high place in the domain of obstetrics, he felt like uttering a few words of caution and warning concerning its use. He thought it was often resorted to when simpler expedients would suffice, and counseled calm deliberation and judg-

ment in every case where they seemed indicated. Thought also, the traction force used should be as little as possible, and the greatest care taken to exercise it in the proper direction.

Dr. Charles G. Stockton thought the paper one of great value, based as it was on personal experiences; said he could best give his views of the subject by relating two cases which would illustrate the points he desired to make. The first case was in the person of a healthy, large, muscular woman, a primipara, to whom he was called one night after she had been in bed several hours. After waiting some time and noting no progress, he applied the forceps, and even used much force, but was wholly unable to cause the head to advance any. Dr. Tremaine was then called and expended all his available strength with a like result; when, finally, Dr. Lothrop came, but whose heroic efforts were rewarded with no better results than those of his muscular predecessors. Notwithstanding all this, at day-break a large child was naturally delivered—dead. The second case was that of a delicate woman who had made slow but gradual progress. Here, as the force seemed sufficient, he decided to wait, and after having been in labor twenty-four hours, the woman was delivered naturally of a dead child, weighing sixteen pounds. The first case did well after her confinement, but the second had a vesico-vaginal fistula, which may, however, have been caused by a calculus, as quite extensive phosphatic deposits were afterward found in the bladder. He used his best judgment in both cases at the time, and thought the question when to use the forceps and when not often a very hard one to decide.

Dr. George E. Fell thought highly of the forceps, and spoke of a very favorable experience with the instrument. He believed, however, that it was too often used carelessly and recklessly, and mentioned a case seen at the hospital where the instrument was brutally used, no care having been taken to apply the traction force in the axis of the pelvic strait, the child having been literally dragged directly through the perineum.

Dr. W. H. Thornton said he had never used the forceps, but believed it could be employed in many cases to the great benefit of both mother and child.

Dr. Thos. Lothrop stated that he applied the forceps now-a-days much less frequently than ten years ago, but he did not wish to be understood as in any way depreciating the judicious use of the instrument, for he regarded it as the most important obstetric aid which we possessed. He had, however, been unsuccessful with it in cases complicated by prolapsed funis.

Dr. C. C. Frederick asked the author if he would dilate and apply the forceps in the first stage of labor under any conditions.

Dr. J. W. Keene said that it had not been necessary, in his

experience, to use the forceps with great frequency. He also thought the application of the instrument to the after-coming head not as easy or as devoid of danger as it was often represented to be.

Dr. F. H. Potter, referring to the adoption of the genu-pectoral posture for repositing prolapsed funis, said that it sometimes entirely suspended labor pains, and always markedly lessened their force for a time, upon which fact greatly depended the possibility of replacing the cord.

Dr. R. L. Banta was greatly interested in the subject, and related, in a humorous way, his first experience in the use of the forceps. He had not obtained much success with the forceps in face presentations, and feared he had done more harm than good with it in those cases; thought it a very difficult matter to apply the instrument to an after-coming head, and even when accomplished, the child would almost invariably be born dead. He also believed it well nigh impossible, in cases of funis prolapse, to save the child with the forceps; and further expressed the opinion that the forceps should never be used in the first stage of labor.

Dr. W. B. Hawkins had been obliged to use the forceps in but three instances, and in each its use was attended with most beneficial results to both mother and child. He felt quite sure that in several cases of tedious labor, due apparently to uterine inertia, he had been able to avoid resorting to the forceps, by the application to the mother's abdomen of large, hot poultices, which, by their heat, very soon stimulated the uterus to firm and regular contractions.

The President remarked that he quite agreed with Dr. Banta in considering it next to impossible to save the child by the use of the forceps in cases of prolapse of the funis; so, too, in all cases of after-coming head. In all such junctures, he preferred to deliver by firm and resolute supra-pubic pressure. The medical world might, he said, be divided with regard to the use of the forceps into two general classes: First, those who always carry the instrument with them when going to attend cases of labor; and, second, those who never take it along, but send for it when needed. The first class make frequent use of it under any and every pretext, while the second rarely invoke its aid, and then only after Nature's powers have been sorely tested and found wanting; or, in other words, under the exigencies of dire necessity. A conservative obstetrician would approve the course of the latter; but it sometimes happened that sudden emergencies arose, when a few moments lost were to miss a golden opportunity to save life. It were better, on the whole, to always be prepared for any contingency, and then act with due deliberation in the use

of the forceps. In a doubtful case whether or not to apply it required much experience and a calm judgment to decide. Where uterine contraction was very strong, and dangerous from its very strength, he believed its application, by hastening delivery, did much good.

The vital points essential to a successful performance of this obstetric operation were, in his opinion, first, the perfection, as near as might be, of one's own self in the application of the instrument ; second, a perfected judgment and perception of the needs of each case ; and, lastly, to carefully study and estimate the amount of force required.

Regarding the pendulum movement in using the forceps, he would only employ it with extreme caution, and after failure with direct traction. He had been able, on a few occasions, to apply the forceps in the Sims' position, after failure in the ordinary way.

Dr. Van Peyma, in closing the discussion, said that often simply introducing the blades, or even but one of them, would rouse the pains, and labor would be completed without the employment of any traction force whatever. On the other hand, he had seen cases where he was obliged to employ all possible force for two hours. In the first stage of labor, he would use forceps after twenty-four hours' delay, especially if the amniotic fluid was escaping ; applying the blades gently at such times, or possibly, only one blade, making gentle, oscillating movements, believing that this procedure would save both mothers and children many times. It was true, he said, that the knee-chest position would sometimes temporarily cause cessation of the pains, but that he had often seen hard pains continue during the whole procedure. In the delivery of the after-coming head, he believed firmly in the efficacy of the forceps, and in the possibility of saving the child by it if used soon enough, reiterating the statement made in the paper that the instrument should be applied if more than two minutes' delay occurred after the birth of the shoulders.

BOOK REVIEWS.

A MANUAL OF MIDWIFERY—By ALFRED LEWIS GALABIN, M. A., M. D. Obstetric Physician and Lecturer on Midwifery and the Diseases of Women to Guy's Hospital, Fellow of the Royal College of Physicians, London, etc. Illustrated with 227 Wood Engravings. P. Blakiston, Son & Co., Phila., Pa.

It would seem from the number of admirable works on obstetrics which have been published within a few years, that the

appearance of an additional specimen in this department just at the present time, were indeed a superfluity. This sentiment will express the feelings of many, on learning for the first time that a new work on midwifery has been sent forth to the medical world. However, one ought not to complain at a superabundance of good things, and Galabin's work is really an excellent one. The aim of the author has evidently been to make a work which should be literally a manual in point of size, and yet include all that is likely to be required by students and practitioners. The method of dealing with certain subjects like the development of the ovum, and the anatomy of the pelvis, from a purely practical standpoint is a good one, and highly commendatory. On the former subject the author only includes what is necessary to a clear understanding of the formation of the placenta and foetal membranes, and on the latter only so much as will have a bearing upon the practice of midwifery. The chapter on ovulation, conception, and menstruation is very clear and elucidates unusually well the relations existing between the different processes so far as known, and the physiological changes peculiar to each. The description of the mechanism of labor is illustrated with some original diagrams, which are good. The "diagram of the head lever" which shows the direction of the transmitted force to the opposite poles of the foetal head, producing head flexion, will prove a decided help to the student in his studies of this subject. The two succeeding diagrams illustrating "the mode in which flexion is produced by the pressure of the girdle of contact with the head," and "the increase of flexion by pressure after the head has entered the genital canal" are also new and worthy of special mention. In the management of protracted labor from an unreduced occipito-posterior position of the vertex, that practically obsolete instrument the vectis is recommended, and we are inclined to the opinion that the recommendation is a good one in those cases where manual efforts are not effectual. Rotation of the occiput forward being the object desired, the author says: "The rotation may then be effected either by a force actually directing the occiput forward, or by one which causes flexion, since it is through defect in flexion that the inclined plane of soft parts fails to turn the occiput forward as usual. Both these indications are fulfilled by the vectis. If the vectis is applied over the occiput and traction made toward the vaginal outlet, as much forward as possible, first, flexion is promoted by the descent of the occiput, and, secondly, the occiput is drawn directly forward, since the vaginal outlet is directed forward in reference to the direction of the pelvic axis at the point where the centre of the head is lying." . . . "Even when called in to perform craniotomy after vigorous efforts to extract with the forceps had failed, I have found that the occi-

put could be turned forward by the vectis with surprising ease, and that then extraction by forceps presented no difficulty whatever."

In the directions for the performance of version in shoulder presentation the writer differs from most English authorities in the choice of the leg to be brought down first, preferring in general to seize the lower leg, or that on the same side as the presenting shoulder. This is the simplest form of version which can effect the desired object, and we believe has much to commend it. No complete rotation of the long axis of the foetus is necessary, its position is already oblique and a slight turn of the body of the child is sufficient to bring the half-breech into the os. Among other recommendations which the author makes, and differing somewhat from the opinions of the majority, may be mentioned the use of the serrated hook for decapitation, and the use, under very exceptional circumstances only, of an oscillatory movement in extracting with forceps. On nearly all other practical subjects, the teaching of the author is in conformity with that generally adopted by the best authorities. On the whole the work is to be highly praised, and shows the author to be highly accomplished in this department of medical research.

THE SURGERY OF THE PANCREAS AS BASED UPON EXPERIMENTS AND CLINICAL RESEARCHES, BY N. SENN, M.D., OF MILWAUKEE, WIS. William J. Doran, printer. Monograph of 128 pages.

The author has made an attempt to "lay the foundation for a rational method of treatment of some of the injuries and diseases of the pancreas by direct surgical measures."

The writer gives the comparative anatomy of the pancreas ; the development ; physiology ; which in itself is a valuable compilation on the subject ; the experiments on that organ ; section (complete) of the pancreas ; laceration of the pancreas ; comminution ; extirpation, complete and partial ; obliteration of the pancreatic duct by elastic constriction ; histological consideration ; fistulas, wounds, gunshot, and other forms ; inflammation, acute and sub-acute ; gangrene ; abscess, pathology, symptoms and diagnosis, prognosis and treatment. In fact, the author here presents a most exhaustive treatise on diseases on that little appreciated and understood gland, the pancreas. It is a pamphlet that should be read by every practitioner in our school.

A LABORATORY GUIDE IN URINALYSIS AND TOXICOLOGY, BY R. A. WITTHAUS, A.M., M.D. William Wood & Co., 57 and 58. Lafayette Place, New York.

This book is a sort of a helping hand to the student doing lab-

oratory work. It is, in other words, a condensed treatise on Urinalysis and Toxicology. To many of our practitioners who have had but limited practical work in the laboratory this little book, 71 pages, would prove invaluable.

NEW MEDICATIONS, BY PROF. DUJARDIN-BEAUMETZ, Paris, France. Translated by E. P. Hurd, M.D., Newburyport, Mass. 320 pp. with appendices and illustrations. Twenty-five cents; two vols. Published by Geo. S. Davis, Detroit, Michigan.

This little work is a part of a series of cheap medical books presented to the profession under the title of *The Physician's Leisure Library*, and will prove not only acceptable, but highly profitable, both to the publisher and the subscribers. This class of reading matter is destined to prove popular, and we predict a warm reception to this innovation. While this volume does not present any remarkable charms for a progressive Homœopath, it furnishes valuable information upon topics of interest to the general practitioner. Some of the old and familiar names appear, such as bromide of potash, quinine, rhubarb, ipecac, squills, and even castor oil, but nevertheless the work is, taken in its entirety, very acceptable, although the price seems ridiculous. We do not hesitate to recommend it.

ELECTROLYSIS: its Theoretical Consideration and its Therapeutical and Surgical Applications. By ROBERT AMORY, A. M., M. D. Octavo, 314 pp. Fully illustrated. Wm. Wood & Co.

This book is a carefully prepared treatise on electrolysis and is of practical use to those who are at all familiar with electricity. The author considers the physical relations of electrolysis—"electrical osmosis." The batteries for electrolysis—on the "resistance" and "diffusion" of the "electrical current." Then the theory of destruction of "living tissue by electrolysis." Method of employing electrolysis in the "living tissue." "Application of electrolysis to the treatment of disease." Basedow's Disease, or Goitre (with illustrations), detailing treatment. Treatment of hypertrichosis (excessive production of hair). The treatment of several cases being reported, showing instruments, manner of using them, and photographs of patients.

DISEASES OF THE NERVES, MUSCLES AND SKIN. By Doctor HERMAN EISCHHORST of Zurich.

As a brief notice of this work we will simply add that Dr. Eischhorst has, in his usual conscientious manner, presented the subject in an acceptable form, and while we find much to admire in the etiology, morbid anatomy and diagnosis of the various

diseases, we appreciate but little the treatment. The department of "diseases of the skin" is especially interesting and instructive. The chapters on parasites of the skin being handsomely illustrated. We regard that part of the book devoted to "diseases of the nerves" one of the most complete and condensed works on the subject in print.

RHEUMATISM : its Nature, its Pathology, and its Successful Treatment. By T. J. MACLAGAN, M.D. Octavo, 285 pp., illustrated. WILLIAM WOOD & Co.

"Rheumatism : its Nature, its Pathology, and *its Successful Treatment.*" On the heels of this statement, on the title page, we find, on the first page of the preface, this significant language : "We have, indeed, no remedy for acute rheumatism." Somewhat inconsistent but characteristic of allopathic works when making an effort to reconcile their remedies to diseases. Did you ever hear the lamentations of an allopathic physician when speaking of their materia medica? This work of Dr. MacLagan is but a fair representation of the literature on rheumatism, and it is a good thing for Wm. Wood & Co. that they have the volume locked up with others in a set, or it would prove a drug on their hands. We do not speak for a hearty reception of the work. The allopaths have much to learn from their homœopathic brethren on the treatment, "successful," at any rate, of rheumatism.

NOTES BY THE WAY.

— In septic fever (following confinement or suppression of uterine conditions by local treatment), if the aggravation comes on about the middle of the afternoon and lasts for several hours, with circumscribed redness of the cheeks (not round spots necessarily), flatulence, constipation, and perhaps other lycopodium symptoms, don't be afraid to give it because it is not classed among the antiseptics; and don't give it too low nor repeat it too often. Nature does not work in a hurry in such fever, but lyco., if too often repeated, may, and you may have to go over the ground twice. If old symptoms crop out under its action wait patiently :

"Suppose the remedy calls out symptoms which have existed already, weeks or months ago. In this case the apparent aggravation, and the development of new symptoms, show that the remedy has attacked the disease in its inmost nature, and will prove of great use hereafter. Therefore the remedy ought to be left undisturbed."

"The physician must have his guard against interrupting the action of the anti-psoric remedy which he has given to the patient. Let him not exhibit an intermediate remedy on account of a little headache which may perhaps come the day after the anti-psoric remedy was given, or another remedy for a sore throat or diarrhœa, or a little pain, etc."

"The rule is that the carefully-selected remedy should act until it has completed its effect."—"Hahnemann's Chronic Diseases."

In any disease, acute or chronic, if the patient *feels* better, whether the local symptoms, subjective or objective, are better or not, *stop the medicine*. The local improvement will follow in due season, sooner or later, according to whether the disease is acute or chronic.—C. B. GILBERT, M.D.

— Physiology and pathology are rapidly demonstrating the fact that a relationship between the tonsils and the genital organs of women has not been established, and yet an interesting point bearing upon this question has been made touching upon the frequency with which tonsillitis occurs in newly-married people. One authority states that he had in several instances known the honeymoon to be interrupted by this painful affection. Dr. Shepard, of Montreal, has always maintained that the old idea was correct, of the intimate association of the tonsils with the female genitals. Will any of the readers of the OBSTETRIC JOURNAL assist us in settling this important question?

— HOW TO PRESERVE RUBBER GOODS.—The rapid deterioration of instruments, syringes, and other rubber articles, has prompted a searching inquiry into the cause and remedy for the peculiar changes that take place, and the following has been found serviceable, although not yet entirely satisfactory:—Drainage tubes, insufflation bulbs, Esmarch's bandages, suffer most. The latter (bandages) should be taken from the boxes at least every month, unrolled and manipulated. Drainage tubes should be hung up in a cool place or soaked in a non-putrescible (not liable to become putrid) fluid. Finally, all objects made of rubber should be kept in a cool place, at a constant temperature, and sheltered from light, heat, and frost.

— HOT WATER IN UTERINE HÆMORRHAGE.—Experiments in the use of hot water to control uterine hæmorrhage with the different degrees of temperature, show that water at 110 to 120 degrees F., contracts bloodvessels and arrests hæmorrhage from small arteries, and at a temperature of from 60 to 100 degrees it dilates small vessels and promotes hæmorrhage; and at a temperature of from 30 to 50 degrees it checks hæmorrhage by constricting the bloodvessels but for a short time only.

— **ETHYL BROMIDE.**—Up to June, 1880, Dr. Turnbull and personal friends of his had exhibited ethyl bromide in nearly nine hundred cases. Since that time it has been used with safety in at least two thousand well-authenticated cases. Ethyl bromide is in some respects the most valuable anæsthetic hitherto used. Its action is exceedingly prompt, and recovery from its effects takes place rapidly. There is less resistance and struggling on the part of the patient than when other anæsthetics are used. Vomiting is less frequent. It is eliminated more rapidly from the body than any other anæsthetic, except nitrous oxide. It is more pleasant to inhale than chloroform, and infinitely pleasanter than ether. It is freely admitted that no anæsthetic can be used with absolute safety.

Ethyl bromide, pure, is therefore recommended for operations not lasting over forty minutes. When of longer duration, the additional use of purified sulphuric ether is advised. When employing ethyl bromide, the administrator must attend to the anæsthetic all the time, so that he can not watch the operation and thus forget the patient for a few seconds. (Why not apply this rule to all forms of anæsthetics?—PORTER.)

As an anæsthetic in labor, ethyl bromide has peculiar advantages from the rapidity of its effects. The patient is comforted between the pains, but never passes into such profound anæsthesia that she is not aroused by the expulsive effort. Full consciousness is retained, and there are none of the depressing effects of ether or chloroform. To the country practitioner, who has to extract teeth or perform minor operations in surgery, ethyl bromide is a great boon, as it acts like nitrous oxide.

Imitations and impurities have in some instances produced deleterious consequences. Specimens have been met with in commerce containing free bromine, phosphorus, bromoform and carbon bromide (C, B₂). Dr. Sims found these remaining as a brown acid liquid of pungent and disagreeable odor. Twenty drops of this liquid given to a rabbit, which had previously taken 30 grains of pure ethyl bromide without the slightest ill effect, produced death in 18 hours.

Dr. Turnbull recommends the following preparatory precautions as being necessary for the safe inhalation of ethyl bromide :

1st. All tight fitting garments about the neck and chest should be loosened. •

2d. The saturated ethyl vapor must be inhaled almost to the exclusion of atmospheric air. The best form of inhaler is a thick towel folded in the form of a cone, closed at the apex with a large pin. A newspaper is to be placed between the folds of the towel.

3d. The patient is to be instructed to make deep and long inspirations. About one fluid drachm is to be placed in the cone,

which must then at once be applied as a cover over the nose and mouth. The cone is not to be removed until anæsthesia is produced, which will be in from 20 to 30 seconds, and which will last for 2 to 3 minutes.—*Medical Clippings.*

[The editor takes pleasure in giving space to the above. In all of our abdominal operations during the last five or six years we have followed T. Spencer Wells' practice of employing no other preparation. It has this decided advantage over chloroform that it is seldom followed by vomiting, and if there is vomiting, very little nausea associated with it.]

— Do not imagine that every lady patient who comes to your office and complains of backache, bearing down pains, irregular menstruation, irritable stomach, is suffering with uterine disorder. A small round ulcer in the rectum will produce all of these symptoms.

—INCONTINENCE OF URINE.—TREATMENT.—First get at the cause, if discoverable, and it generally is. Divide your treatment into two classes and both must be modified by the diathesis and idiosyncrasy. In hyperæsthesia, allay irritability.

After prescribing your "pet remedy" for the incontinence or having selected the properly indicated drug, which come under the first-class, the second-class, or when the anæsthesia is more or less marked, should be considered. As a rule, narcotics, although mighty tempting, are more injurious than beneficial. In the case of an abnormally small bladder, usually found in scorbutic children, forcibly washing it out—adding to the quantity of water used each time—is highly recommended by some of our German authors. Winckel, of Dresden, cured a chronic case when there was irritability associated with a small bladder, by injecting a solution of nitrate of silver. This gentleman also found good results from the use of the electric current, applied in the following manner: "Place one pole (thoroughly insulated up to the point to be used) in the bladder and the other pole over the pubic symphysis and loins, letting the current flow in various directions, through, over, and into the affected organs."

Cold baths and cold douches to the spine at night have proved of great service.

If the cause be abnormality of the urine, such as lithiasis, oxaluria and acidity, it should be corrected by drinking some neutralizing agent like

℞ Potass Bicarbonatis,
Potass Citratis, āā ʒ ss,
Syrupi Simplicis, ʒ iv.

M.

Sig.—Take one teaspoonful in half tumbler of water, adding two ounces of lemon juice. Drink while effervescing.

Or give buchu in some form.

Prof. S. G. Armour, late Dean of the Long Island College Hospital, a gentleman to the manor born—God bless his memory—once stated, when lecturing on irritability of the bladder, that buchu stood in the same relation to the bladder that bismuth did to the digestive tract, almost universal in its application to disease in that part.

The "liquor potash, the bicarbonate and iodide of potash also possess a high degree of utility in the class of cases referred to, and their therapeutical action is certainly never disturbed by administering them." When there is a gouty and lithic acid diathesis, the carbonate of lithium is a remedy of undoubted efficacy.

℞ Carbonate of Lithium, $\frac{3}{4}$ ss.
Benzoic Acid, 3 xiii.

Dissolve the acid in 10 per cent. biborate of soda ; then add lithia and distilled water to make $\frac{3}{4}$ vi. A teaspoonful four times daily with copious draughts of water.

Limpid urine is usually due to some general nervous trouble or cerebral disease.

Deposits of amorphous or triple phosphates are rare, unless there is some organic disease of the bladder. When the deposits are not due to decomposition, some decided nerve trouble is usually present, and here, as in limpidity, the general condition must be regarded.

In oxaluria attention must be paid to the moral, mental, and physical condition, and time must not be wasted in treating mere symptoms. The following is by many looked upon as almost a specific :

℞ Acid Nitro-Mur. dil. 3 v.
Tr. Nux. Vom., 3 iii.
Olei Gaultheriæ, mxii.
Aqua. Ad., $\frac{3}{4}$ iii.

M.

Sig.—One teaspoonful before each meal.

—CYSTITIS.—Benzoic acid, in ten grain doses, in infusion of buchu, three or four times daily, is by many considered a specific for chronic cystitis in the female. The bladder should be washed out and medicated injections used. Employ a catheter with small holes in the end, extending back about an inch, instead of the ordinary metallic female catheter, with one or two large openings at the end. The great objection to this instrument is, that when the bladder is empty the mucous membrane passes into these apertures and is almost sure to be injured when the catheter is withdrawn. This objection, to some extent, also applies to a soft

rubber male catheter. Briefly, then, we would suggest that if the physician does not care to provide himself with a complete kit of instruments for treating the female bladder, that he now add to the catheter an ordinary piece of small rubber tubing, large enough to pass over the end of the catheter, and all injections given with care. Remember the following rules : 1. Never inject over one ounce at a time. This can be repeated, however, until four ounces have been used. 2. Inject slowly as possible, and let the flow be regular, avoiding all jerking with the syringe. Never think of filling the bladder suddenly. Washing out the bladder with hot water in any disease of that organ is always beneficial. It should always be done before using any medicated injection. Add common table salt, about 60 grains to the pint, when employing the hot water. Carbolic acid should be employed in ulceration or suppuration, one drop of the acid to ten or twenty of the water. Calendula and baptisia, 1 to 4, is also an excellent wash when the above condition exists. When astringents are required, silver nit. zinc, tannic acid, 3 ii to 3 i of Pond's Extract, act. of lead, can all be employed with more or less success. The usual formula is two grains of either to ounce of hot water. Never give an injection that produces pain. The well known virtues of hydrastis, nitro-hydrochloric acid should not be forgotten. In cases of long standing, applications by instillation is an excellent manner of treating them. The tube used is nothing more or less than a long dropping tube of glass, with a rubber compressing bulb. The point is curved, and with care, oil and a little time it can be carried into the bladder, and any liquid deposited upon the diseased mucous membrane you may wish. Usually not more than five or ten drops should be employed at one treatment. Doctor Gouley gives this valuable advice in the treatment of cystitis in the female bladder : If you wish to employ nitrate of silver in a strong solution inject but a few drops only at each sitting, say five to ten drops. If you desire to use a mild solution, inject a larger quantity, one or two drachms. If the urethra is tender and inflamed, it may prove an obstacle ; before we were supplied with that valuable agent, cocaine, we often injected the solution by using one of the ordinary P. P. syringes, with an acorn bulb point, which could be inserted into the meatus urinarius and the solution slowly forced up through the urethra into the bladder. Now, however, we fill the urethra with cocaine—10% solution—and after waiting a few minutes, pass the instillation tube or catheter into the bladder without any inconvenience to the patient. Permanganate of zinc is also an excellent remedy in cystitis ; it should be used never stronger than one grain to the ounce of water.

When treating a patient for any bladder, urethra or uterine trouble, always place them on a table, where you will not only

have plenty of light, but also plenty of working space. There is nothing so awkward as an operator treating a patient on a bed or a low couch or sofa. Insist upon having room and assistants.

—TONSILLOTOMY.—Never perform tonsillotomy upon a young girl until after menstruation has been established.

—The following letter to the editor explains itself, but we feel that the subject is of too great an importance to be confined to a limited number. We therefore invite our readers to give the subject their candid consideration and forward their reply to Dr. J. W. Crumbaugh.

DR. PHILIP PORTER,

I beg to submit to you a few questions regarding your treatment of diphtheria. I have written besides you, other physicians in this country and abroad on the same subject. My object is to ascertain to what your successes are due and to embody the same in a paper now in preparation, in which due credit will be given all.

QUESTIONS.

1. What remedies have proven most effectual in your hands in the treatment of diphtheria?
2. Have you indications for your remedies other than those usually given?
3. Do you use local measures in this disease? What?
4. What success in the medicinal treatment of laryngeal form? Remedies.
5. Do you or do you not approve of tracheotomy in laryngeal diphtheria?
6. What remedies in post-diphtheritic paralysis?
7. What treatment in threatened hrt. exhaustion following diphtheria?
8. What treatment in typhoid state sometimes accompanying or following the shedding of membrane?

—PUERPERAL ECLAMPSIA.—Dr. Crow in an address before the Atlanta Society of Medicine as reported in the *Atlanta Journal*, stated that he defined "puerperal eclampsia as a convulsion of epileptiform type, characterized by loss of consciousness and of sensibility, together with toxic and clonic spasms, occurring during the puerperal state."

Several conditions concur in this disorder, which are, (1) the hydræmic state of gestation leading to imperfect nutrition of the nervous centres, increasing (2) the normal nervous tension and irritability and (3) the normal vascular tension; with these comes

(4) blood poisoning from imperfect eliminations of waste stuff by the kidneys and other excretories.

—**ABDOMINAL OPERATIONS.**—In all operations here, the rule should be, never to disturb the dressing from the time it is put on the wound is healed. The temperature is the guide, and unless it goes up and persists, or unless the symptoms should indicate secondary hæmorrhage or something of this sort, the dressing is never changed.

—Dr. W. P. Copeland, of Eufaula, Ala., writes to the *Medical Record*, "In almost every community there are old who suffer from a chronic inflammation of the neck of the bladder, rendering them miserable sufferers and a care and anxiety to their friends and families. Having had the professional care of several of this class of cases, and dreading the tendency they so frequently acquire to the administration of opium for the relief of pain, I resorted to various washes for injecting the bladder, resulting in my adopting a solution of benzoate of soda, ten grains to one ounce of water, with twenty to thirty drops of the green tincture of gelsemium; this is warmed and injected by the patient through a soft rubber catheter, whenever the pain is severe, and the catheter withdrawn, leaving the medicine to be voided in twenty to thirty minutes; or, where she is not able to pass any thing from the bladder, the catheter is re-introduced and the medicine allowed to escape. My experience with this treatment has been so satisfactory that I can not refrain from giving it publicity to the profession."

—Eggert states that the following remedies are to be consulted when treating anteversion: cal. phos., caul., graph., helon., lil. tig., nux m., sepia and tarant.

Retroversion: æs. hip., cal. phos., cimicifuga, ferr. jod., lil. tig., sepia and tranula.

Anteflexion: gel.

Retroflexion: caul., hel., lil., and sepia.

Prolapsus after cessation of menses: agarie. m., kreasot.

Prolapsus after parturition: bell., nux v., pod. and rhus tox.

Prolapsus with prolapsus of vagina. Aurum. ferr., merc., nux m., nux v., sepia, and stan.

Prolapsus with prolapsus recti: pod. and sul.

Prolapsus from muscular atony: Alet. far., cimicif., helon.

—**REMEDIES INDICATED IN UTERINE DISORDERS, BY TIME OF AGGRAVATION.**—"Aggravation of symptoms after a long walk. Rhus tox.

Aggravation after sleep: especially after a siesta. Lach.

Aggravation after 3 A. M. Kali. carb.
 Aggravation at night. Cham., nit. acid.
 Aggravation at night and from the heat of the bed. Merc., sulph.
 Aggravation every other day. Alumina, china.
 Aggravation from coffee ; noise ; tobacco ; reading ; sunlight. Ignatia, bell.
 Aggravation from coition and menses. Kali c.
 Aggravation from cold, wet or windy weather. Nux m., dul.
 Aggravation from dry weather. Alumina.
 Aggravation from 4 to 8 P. M. Lyc.
 Aggravation from heat. Puls.
 Aggravation from riding in carriage. Nux m.
 Aggravation from standing. Sulph.
 Aggravation in open air. Cham.
 Aggravation in the evening. Nit. ac., puls.
 Aggravation in the morning. Ignat., nux v.
 Aggravation when at rest. Plat., puls., sul.
 Aggravation while lying on the left side. Puls.
 Amelioration of symptoms after sweating. Cham.
 Amelioration during menses. Zinc.
 Amelioration in open air. Alumina., puls.
 Amelioration in wet weather. Alumina.
 Amelioration from changing position. Ignat.
 Amelioration from eructation. Nit. acid.
 Amelioration when lying on painful side. Ignat.
 Amelioration from motion. Plat.
 Amelioration from riding in carriage. Nit. acid.
 (Worse from riding in carriage. Nux m.)
 Amelioration from warmth ; warm weather. Nux m.
 Amelioration on rising. Cham.
 Amelioration when walking. Cham.
 "All motions are painful. Pallad."

Palladium, which closely resembles platinum in color and appearances, is truly a remedy not yet fully appreciated by our gynæcologists in treating both diseases of the uterus and ovary. Minton in his admirable work on "Uterine Therapeutics" gives a condensed history and the indications for the use of palladium.

It is indicated in nursing women who menstruate. The leucorrhœa is "transparent, jelly-like discharge, worse before and after menstruation. Heaviness and weight in the pelvis. Pain and weakness as if the uterus were sinking down."

As an ovarian remedy it is par excellence. Drawing down and forward in the region of the right ovary, which is relieved by rubbing. Swelling and induration of the right ovary (this remedy takes the place of the fashionable operation oöphorectomy) with

soreness and a shooting pain from the navel to the pelvis, with a weight and heaviness in the pelvis, worse from exertion and while standing; better when lying upon the left side.

Pain in the small of the back and hips (lumbo-sacral pain) with coldness of the extremities. "Sharp knife-like pains in the uterus, better after stool." This latter symptom applies to the left ovary and we account for it by the mechanical fact, that pressure is relieved from the left ovarian vein by emptying the sigmoid plexure of its contents; this vein passing under that portion of the lower intestine.

All the symptoms of palladium are aggravated "on standing and from motion."

Amelioration when lying down, and lying on the opposite side from the diseased ovary. Better after sleep.

—OVI TESTA.—This remedy was first brought prominently to the notice of the profession by Doctor Susan Edson, of Washington, D. C., who recommended its use in relieving the pain in epithelioma of the cervix or uterus. It has been our personal experience, however, after an impartial trial, that it has not the slightest influence over the pain usually associated with scirrhus or epithelioma of the uterus. The characteristic indication of ovi testa as given by Doctor Edson is the broken-back feeling. The leucorrhœa is profuse; white or a yellow-greenish and ichorous in character. This drug, no doubt, has its sphere in certain forms of scorbutic troubles and should also prove a valuable remedy in diseases where there is an organic alteration in the textures. While the evidence of those who claim certain specific relations between ovi testa and cancer of the uterus may be perfectly honest, we can not but think it was one of those cases of an "error in diagnosis."

—STROPHANTHUS AS A CARDIAC REMEDY.—Fraser & Co. are authority for the statement that strophanthus has "shown to be more powerful in its action on the heart and less on the blood-vessels than digitalis. Also less productive of sickness and gastro-intestinal disturbance. Strophanthus is *not* accumulative in its effect." They recommend it in tincture, one drachm liq. aurant. comp. four ounces, one teaspoonful of the mixture every three hours. We employ it in the form of tablets 1 m., in each tablet.

—TO PREPARE LIGATURES.—Prof. Gross uses Macewen's method: Take one drachm of chromic acid (crystals) to five ounces of water; of this solution take one ounce and add to it an ounce of glycerine. In this latter steep the animal ligatures ten days, then remove and thoroughly dry them. Now, for preserva-

tion, keep them in a 5-100 solution of carbolic acid.—*Col. and Clin. Rec.*

—**SUTURES—SILK WORM GUT.**—The silk worm gut sutures are rapidly displacing the silk wire suture. If immersed for ten or twenty minutes in hot water—say 110° they become perfectly soft and pliable. You can introduce them anywhere you can the silver wire and when the time for removal comes, their superiority becomes at once very apparent. You never torture your patient when using the silk worm gut or the horse hair suture.

—**INTRA-UTERINE GALVANO-CAUTERY.**—We have received from Dr. G. Apostoli, of Paris, some preliminary notes giving the results of his observations upon the use of the intra-uterine galvanocautery in the treatment of certain uterine affections, of which the following are the chief: Uterine fibromata, certain forms of chronic metritis, certain intra-uterine polypi, unilocular cysts of ovary in their earlier stages, chronic cellulitis of the broad ligament, sub-acute and chronic peri-metritis, hæmatocele and extra-uterine pregnancy. It is claimed for this mode of treatment that it is scientifically exact, since the strength of the current may be accurately measured in milliamperes; that it is painless, since the covering of potter's earth, which the author recommends, for the external electrode prevents the excessive pain which would otherwise accompany its application; that it is harmless, as proven by the author's experience with 200 cases; and more than all, that it is curative, since in 95 per cent. of all the cases in which it was employed, satisfactory results followed. The time occupied by the treatment varies from three to nine months. The apparatus necessary for this method of procedure consists of a galvanometer graduated up to 200 milliamperes, a battery capable of giving a current of from 100 to 200 milliamperes in intensity, an intra-uterine electrode of platinum insulated by a celluloid covering in its vaginal portion, an external electrode covered by potter's earth to prevent pain, burning and sloughing, strong, flexible cords which will not be liable to interrupt the current by breaking. The *technique* of the method involves many minute details, all of which, according to the author, are essential to success.—*Atlanta Journal.*

ABSTRACTS.

—**CONTRACTION, INHIBITION, AND EXPANSION OF THE UTERUS.** Dr. Matthews Duncan, London Obstetrical Society.—The uterus proper, or its body, was chiefly considered, but not to the entire exclusion of the cervix uteri and vagina. Contraction was

temporary, and followed by relaxation and return to original dimension. It might be morbid in force, in duration, in rhythm, or in extent. Contractions were believed to be present in childhood, and in the whole of menstrual life, and especially in menstruation. They were morbid in dysmenorrhœa spasmodica, and might be tetanic. The rate might be six in an hour. Contraction, perhaps, occurred in a fibroid, certainly around it, and especially at menstrual periods. The healthy contractions of pregnancy, to which Dr. Braxton Hicks had devoted much attention, were considered. They might be morbid and painful. Then came the contractions of abortion, miscarriage, and labor at term, and in the puerperal state. The commencement of labor was then discussed; it was not the commencement of contractions, but of inhibition and of retraction. The internal os uteri was not the weakest part, but the fundus; at least, according to mechanical principles. Stretching of fibres did not explain the commencement of labor. The uterus grew, and it was expanded by growth and a very slight force. The analogy of urination and of defæcation with labor was considered. The necessity of inhibition of the circular fibres of the lower segment of the uterus was noticed. Morbid changes of inhibition were pointed out. Lastly, the power of arresting and inducing contraction was mentioned.

Dr. Herman had had under his care, in the London Hospital, a case somewhat analogous to the examples of painful uterine contractions during pregnancy which Dr. Duncan had related. It was that of a patient with fibroids of the uterus, who suffered from severe paroxysmal uterine pains throughout the intermenstrual period, these pains being only absent during menstruation. She was treated with ergot, which aggravated the pains. The cervix uteri was then dilated, after which the pains ceased, and they were absent for two or three months. They then returned, and the cervical canal was again dilated, and the pains were again removed. After this, he lost sight of the patient.

Dr. Champneys said that the antagonism existing between the opposite poles in the uterus had been called polarity by Reil, and he thought it was a convenient and concise term. He thought that spontaneous yielding of the cervix could not be denied in face of the following facts. In labor, with contracted pelvis, the head was sometimes arrested above the brim; the membranes presented in the shape of the finger of a glove; but, in spite of these conditions, the cervix was found by the hand (introduced, perhaps, for the sake of turning) hanging flabby and relaxed, almost as if labor had already occurred. Again, it sometimes happened that the os tincæ refused to dilate, and remained rigid, however strong the pains might be. Under these circumstances, great retraction might take place, and Bandl's ring might be felt high up, the lower uter-

ine segment being greatly thinned. The expansion which should possess the lower pole of the uterus was replaced by contraction, and the result was a dead lock. In such a case, in presence of accidental hæmorrhage, he had turned, brought down a foot, and (apparently from reduction in the contents of the uterus) the cervix relaxed. He thought it could not be maintained that the external cervix was stronger than the internal. He would ask Dr. Duncan whether he had been able to distinguish the contractions of the vagina from those of muscles near it. Painful labor-pains during pregnancy were like those of other hollow viscera, in which disorderly contractions produced colic.

Dr. Braxton Hicks wished to point out a fact not alluded to—namely, that, during the last six weeks of normal pregnancy, the os and cervix were, in a large number of cases, patent enough for one or two fingers to be readily passed in. When proceeding to induce labor at seven and a half or eight months, he was often able to employ at once the largest size of Barnes's bags. The subject of the paper could not be fully discussed without this fact being taken into account.

Dr. Horrocks said that physiologists had formulated a law that, whenever a muscle contracted, its opponent relaxed. This law was applicable to all muscles, voluntary or involuntary. He illustrated the law by reference to various groups of muscles. The sphincter of the orifice of a cavity was the opponent of the walls of the cavity. Hence the cervix uteri relaxed when the fundus contracted. This was a physiological process known as inhibition, and, doubtless, had some nerve-centre in the spinal cord or sympathetic plexuses presiding over it. If the longitudinal fibres in the cervix assisted in opening the cervical canal, they were, no doubt, acting when their opponents, the circular fibres, were relaxing. Were there any means of affecting this inhibition and contraction by drugs or electricity? In his hands, electricity had failed to bring on labor. Chloroform, chloral, and opium might, to some extent, inhibit uterine muscular action, but not electricity.

—MITRAL STENOSIS IN LABOR.—Dr. George Coates described this case. The patient was aged 22, and had suffered from rheumatic fever, but had no suspicion of heart-disease. She had suffered from anæmia and breathlessness. The labor began on October 23, 1885. On the 24th she felt faint several times. On examining the heart, a presystolic murmur at the apex was detected. In the evening the os uteri was fully dilated, and she showed signs of exhaustion. The forceps was put on and delivery accomplished. The pulse varied in the next two hours from 180 to 130, then it fell to 108, and in the morning to 76. The murmur

disappeared on and after the tenth day. On November 13 she had a rigor, and sharp pain in the left breast, and one elbow. She was treated for acute rheumatism, and recovered. The murmur quite disappeared.

Dr. Herman thought Dr. Coates's case interesting and instructive. He would be largely guided in the management of heart-disease, during pregnancy, by Dr. Angus Macdonald's writings; but he thought that author took too unfavorable a view of the prognosis. Published cases and consultation cases contained too large a proportion of bad cases. Dr. Coates's case showed that pregnancy and labor might be gone through safely.

Dr. Champneys said that Dr. Coates's case differed in many respects from those which had been recorded and those that he had seen. There was no aggravation of symptoms at the end of pregnancy, no distress during labor, and no alarming symptoms soon after, when the blood pressure fell. Dr. Macdonald's work was founded on a very few observations, and recorded cases were valuable. Stenosis was supposed to be the most dangerous form of mischief under the circumstances.—*Ibid.*

—ELASTICITY, RETRACTION, AND POLARITY OF THE UTERUS.—

Dr. J. Matthews Duncan read a paper bearing this title. Retractivity had been defined as that property of the uterine tissue, in virtue of which the womb, emptied of a part, or of the whole, of its contents, acquired a great thickness of wall, at the same time that its volume and its capacity were diminished. It was a function of muscular tissue, and it got only a little supplementary aid from elasticity. The elasticity of each of the three layers of the uterine wall was discussed, as it existed in healthy and in morbid conditions. Retraction was not merely a condition, it was a force. During pregnancy, it was a mere tonic tightening. In labor, its action was necessary; in labor, there was inhibition of it in the circular fibres of the lower segment of the uterus, and in the whole cervix and vagina. Retraction implied expulsion of contents, but the retraction was not necessarily in proportion to the advance of contents. There was, probably, an essential difference between contraction and retraction; each might go on without the other. The usual comparisons of the action of the uterus and of the heart were criticised, and a new comparison suggested between the whole of pregnancy and a diastole, and the whole of labor and a systole. The expulsion of a fibroid was cited in corroboration and illustration. Cases of morbid retraction, and of morbid absence of retraction, were mentioned. Ergot caused retraction and not contraction, and hence its failures, its injuries, and its benefits. Dr. John Williams described the retraction of menstruation. Uterine polarity, described by Reil, and re-described by Champneys, was referred to, and illustrations of its action given.

Dr. Galabin agreed with almost the whole of the author's description of retraction of the uterus. He was surprised to hear it stated, however, that ergot produced only retraction, and not contraction. If this were so, then the general opinion that, in some cases, ergot acted as an oxytoxic, and hastened delivery, or completed when nature could not, must be wrong. Rupture of the uterus occurred in some cases of obstructed labor after the use of ergot, intense rhythmical pains having preceded the rupture. In such cases, he did not think rupture could be accounted for by continuous tension and pressure, due to retraction, having weakened the vitality of the tissue. Perhaps the explanation was, that Dr. Duncan refused the title of contraction to that kind of contraction which was the initial stage of retraction. Such a use of the words could not be maintained. By contraction, he understood shortening and thickening of the muscular fibres; by retraction, a similar shortening and thickening not followed by relaxation and lengthening, but leaving a permanent shrinking after the tension of the contraction had passed off. Retraction was contraction and something more. The contraction itself was identical in the two cases. Thus, in *post-partum* hæmorrhage, the contraction was the same, whether it were followed by relaxation and renewal of hæmorrhage, or ended in retraction and arrest of hæmorrhage. He believed that ergot had the power of intensifying both effects in variable degrees in different cases, both the initial rhythmical contraction and the subsequently persisting tonic contraction which maintained the shrinking produced by it.

Dr. Horrocks observed that elasticity of muscular fibre, though nearly perfect, was not sufficient in amount to diminish the size of the uterus after labor. With removal of the stretching force, muscular fibre regained its normal size. Retraction meant contraction not followed by relaxation. A contracted muscle felt hard; a retracted one did not. Retraction after parturition was probably due to the absence of sufficient force inside the cavity to stretch the fibres to their former length. Polarity of the uterus was merely a part of the great general question of relaxation of opponent muscles. He illustrated this by reference to various groups of muscles. Relaxation of fibres of the cervix during the contraction of those of the fundus was merely one example of the general law. He then discussed 'reflex tone' of muscles, and pointed out that in defæcation, micturition, and parturition, there is a reflex tonic contraction kept up in the muscular fibres, especially in the sphincter. The contraction of the sphincters would be inhibited, and the nerve-centers for inhibition were closely associated with those for contraction. Defæcation, micturition, and parturition, could take place independently of volition, or

even of consciousness. The will had, however, a modified power over them, and could help to start them. Finally, ergot would cause contraction of muscular fibre, because it had been given successfully, many times, to bring on premature labor.

Dr. Champneys had difficulty in accepting the teaching that ergot produced retraction. He did not believe that it produced true contraction, neither did he believe that it produced true retraction. Ergot often produced a contraction of limited extent, and then tetanus; the organ contracting, and then remaining of the same size, but hard and rigid. This was rather tonic contraction than retraction. With regard to polarity, the action of opponents, referred to by Dr. Horrocks, was exemplified in the uterus by conditions involving a disturbance of the normal condition, in which consentaneous, though opposite, action, was observed in the upper and lower poles, such as incarceration of the placenta, after-pains, and some forms of dysmenorrhœa—conditions analogous to colic in other hollow muscular viscera, the pain being due to violent opposition instead of normal yielding of one muscle to another.

Dr. Sloan, of Glasgow, thought it must be admitted that retraction differed from contraction; for, after the uterus was quite emptied, we found, in the intervals of the pains free from tonic contraction, the uterus smaller, that is, retracted. He thought morphine was the exact opponent of ergot in its action on the lower segment of the uterus. It caused inhibition of this segment, and thus accelerated dilatation. He suggested that great mental distress, as in unmarried women, by preventing healthy retraction, favored absorption and puerperal fever.—*Ibid.*

—**SEROUS PERIMETRITIS.**—Dr. Amand Routh read this contribution. The disease was brought on by a chill, during menstruation, in a woman, aged 27, suffering from subinvolution and its consequences. The uterus was fixed, and there was bulging downwards of the pouch of Douglas, with two fluctuating points. Each was aspirated, $3\frac{1}{2}$ and $1\frac{1}{2}$ ounces of clear serum being drawn from them. The intestines were matted, forming a large hypogastric tumor, which varied with their distension. The patient speedily recovered after the aspiration, but had a slight relapse at her next menstruation, the temperature rising to 100° Fahr. The researches of Drs. M. Duncan and J. Williams were noticed; and the opinion was hazarded that these cases were more common than was supposed, and were often diagnosed as hæmatocele. The diagnosis between serous and purulent perimetritis was only certain after aspiration. Mr. Burton's theory that these effusions were due to pelvic hæmatocele was opposed to the author's opinion, that they were due to physiological congestion of the uterus during menstruation, being changed into inflammation by

a chill ; such inflammation spreading, by continuity of tissue, either along the Fallopian tubes or through the uterine tissue to the peritoneum. Extreme cases of bulging of the pouch of Douglas were alluded to, caused, as Dr. John Williams had shown, by adhesive lymph fixing the intestines above, and so preventing the serous fluid from rising up into the pelvis.

Mr. Doran said that the case tended to prove the true signification of the term "serous perimetritis." Some irritant material from the tubes or elsewhere set up peritonitis. The uterus, tubes, and intestines happened to adhere in such a manner as to cut off a segment of the peritoneum. This was the first essential condition. The inflammatory process not being of a low type, serum, instead of pus, was poured out into the portion of peritoneum shut off from the general cavity. This was the remaining essential feature in that accidental variety of pelvic peritonitis, conveniently termed "serous perimetritis." He could not understand Dr. Routh's theory about the share which the posterior layer of the broad ligament might take in this disease. He described the actual anatomical relations of the parts, and pointed out that they explained the rapid matting of ovary, tube, and broad ligament in such cases ; but, in some, intestine might displace the tube, and come into contact with the broad ligament, and adhere to it.—*Ibid.*

—A DOUBTING THOMAS.—It seems from the tone of the following note that even there are certain allopaths who decline to accept every thing as "law and gospel" that comes from Lawson Tait : "Mr. Lawson Tait operates in his own hospital, keeps his patients under his own observation, under his own hand, watching them with much care, and exercising the greatest cleanliness."—*Texas Courier Record.*

"Yes, and even though he does all this, we would as soon believe that he could turn water into wine, raise the dead Lazarus, feed five thousand hungry travelers with five loaves and seven fishes, or perform any other miracle, as to swallow his statement that he had operated 138 consecutive times on as many unselected cases of ovarian tumor without a single death."—*Weekly Review.*

—VAGINAL ALIMENTATION.—It is astonishing how much the profession are awaking to the necessity of more food, proper food, given at the proper time and under the proper conditions. Dr. I. N. Love, of St. Louis, in a very interesting and instructive paper read before the Mississippi Valley Medical Society at its meeting at Quincy, on "Artificial Alimentation and Medication, Hypodermic, Rectal and Vaginal," calls attention for the first time, we think, to the value of the vaginal canal as a receptacle

for food which is easily absorbed and taken into the circulation. He says :

"Where the conditions will allow, the necessity of properly nourishing our patient being urgent, we may use the vaginal cavity alone as a means of introducing peptones and medicines into the circulation, or in conjunction with other channels. The canal varies in capacity and distensibility, and, of course, the extent of absorbing surface is not as great as in the bowel, but there can be no question that it is sufficient to aid nutrition, and we can absolutely depend upon it for the administration of such medicines as we may desire to give in order to obtain constitutional effects.

"In the administration of drugs by this means, I usually give them in the form of suppositories, or when a more rapid effect is desired, in solution with warm water, one or two tablespoonfuls.

"In administering food, the liquid peptones should be given carefully as by the rectum, in a smaller quantity, but oftener. Semi-solid masses, such as thoroughly minced and macerated raw beef with minced sweet-breads, I have found can be given very conveniently by using Anderson's vaginal capsules in sizes to suit the case.

"After the introduction of the food or medicament, I have usually placed over the vaginal opening a small mass of absorbent cotton covered with oil silk, and held in position by a T bandage.

"I have used this means of nourishing and medicating my patients in probably a dozen instances since my first experience, and I feel safe in arriving at the following conclusions regarding vaginal alimentation and medication, viz :

1. In cases which demand artificial alimentation where the conditions will permit, the vagina may be utilized to supplement feeding by the rectum.

2. In some instances of the alimentary canal in its entirety precludes feeding by either the stomach or the rectum. In such cases the vagina may be utilized to practical advantage.

3. That whether the vagina or rectum be used for purposes of feeding, the materials should be as thoroughly digested previous to using as is possible ; the milk, albumen or beef fibre completely peptonized, and the starchy matters changed into dextrose or glucose.

4. In many instances the vagina may be utilized for purposes of general medication and stimulation, and the stomach saved for the important one of feeding.

5. In many cases vaginal feeding, stimulation and medication is beneficial ; in many others it is a potent means for saving and prolonging life.

6. In both rectal and vaginal feeding the same gentle care is necessary, and one advantage possessed by the latter over the

former is that the vagina is much the more tolerant of intrusion, and can be utilized for an almost unlimited time without revolting."

Surely here is a field for experimentation, and we feel confident that the profession will feel indebted to Dr. Love for drawing attention to so important a matter.

—THE NECESSITY OF CUTTING CONTRACTED TISSUES IN CASES OF DEFORMITY, BEFORE TRACTION IS ATTEMPTED.—BY LEWIS A. SAYRE, M. D.—On the 19th of March, 1886, my son, Dr. L. H. Sayre, read a paper before the Orthopædic Section of the New York Academy of Medicine, on "The necessity of recognizing 'Reflex Spasm,' produced by 'Point Pressure,' in *contractured* tissues, and making proper section of the same, before any mechanical appliance can be effectually used."

This paper, which I considered of great practical importance, does not seem to have produced the effect on the profession that I had expected, for within the past few weeks I have had several cases of Talipes brought to me where traction, aided by very ingeniously contrived extension apparatus, had been most faithfully employed for many months without the slightest benefit, because the parts were *contractured* and therefore could not be stretched.

The only hope of affording relief in this class of cases is by *section* of the *contractured* tissues, and this doctrine I have taught for many years. I draw a distinction between a *contracted* and a *contractured* tissue.

A *contracted* tissue is one that is merely shortened, but which can be elongated by careful, continuous and judiciously applied traction, and therefore does not require to be divided. But a *contractured* tissue is one which has undergone some structural change, and which can not be elongated unless the tissues are severed or torn, and therefore section in such cases is always necessary. How are we to know whether the tissue is *contracted* or *contractured*.

If, in any case of club-foot or other deformity from muscular contraction, we stretch the shortened parts to their utmost tension by manual force or otherwise, and while the parts are thus stretched we suddenly add to the tension by pressing with the thumb or finger on the part thus stretched, and it causes a reflex spasm or sudden shivering of the whole body, that muscle-tendon or tissue is *contractured*, and can not be elongated without severance of its fibres.

If, on the contrary, when the test is applied as above described, and no reflex irritation or muscular spasm is produced, it is evident that the parts are simply *contracted*, and can be further

elongated by persistent constant traction, and therefore do not require division.

This is a very important rule to observe in practice as it will save the surgeon a great deal of valuable time, the patient months of useless and unnecessary torture, and always yield the most satisfactory results.

I have tested this rule for the past twenty years, by the careful observation of many hundred cases, without a failure in a single instance of its proving correct, and I therefore feel almost justified in laying it down as a law of universal application in all cases of *contractured* tissues.

I do not know that I can better illustrate the importance of recognizing this law than by narrating one or two of the many cases that have fallen under my notice, and in which its adoption has proved of immediate and permanent advantage.

Some three years since, Dr. T. Gaillard Thomas brought a gentleman to my office with his little son about six years old, who was suffering from congenital equino-varus of both feet in a very marked degree.

He had been subjected to various treatment since early infancy, and for the past twelve months had been visited daily at his house by a prominent orthopædic surgeon of this city, who had applied for a few minutes to each foot daily, during all this time, a shoe of his own construction which was capable of making *very powerful* traction upon the contractured parts; but as the father and Dr. Thomas both stated, without having produced the slightest change in the deformity.

But the effect of the torture had made such an impression on the child's nervous system that he was almost ungovernable and would submit to the treatment no longer. Upon stretching his foot with one hand, and pressing with the fore-finger of the other on the tense plantar fascia, an instantaneous spasm of almost all the muscles of the body was produced, and the child screamed in agony. The same result was produced when the same test was applied to the plantar fascia of the other foot, and also when applied to the tendo-Achillis of either side.

Dr. Thomas was convinced after this examination of the folly of attempting to stretch such tissues, and advised the father to place the child under my care.

The same afternoon I went to his house in the upper part of the city, and assisted by my son, and Dr. Develin, who administered the chloroform, and in the presence of Dr. Walker, Dr. Thomas' assistant, I divided subcutaneously the plantar fascia, tibialis anticus and tendo-Achillis of either side, and *immediately* restored the feet to their normal position, and dressed them in my usual way while he was still under the anæsthetic. I visited him on the

following day, and to my surprise he put out his hand and greeted me with a cordial welcome, instead of screaming, as the mother said he had always done before when any doctor came to see him. The father said that he had behaved so differently from what he had ever done before, and seemed so happy that he acted like a "re-constructed" boy.

The dressings were removed for the first time on the fourteenth day, when all the wounds were perfectly healed without a drop of pus, and the Achillis-tendon was so firmly united that he could voluntarily extend either foot even when quite firm resistance was made against the bottom of the same. He was measured for a new pair of shoes, as his feet were so much longer that he could not wear his old ones, and the foot-board and adhesive plaster re-applied for another week as a means of protection until the organization should become more firm. Three weeks from the time of the operation he walked very well with both heels upon the floor in an ordinary shoe, simply requiring Hudson's elastic attachment to aid in flexing the feet.

These he wore for nearly a year, when by the daily use of electricity, massage and manipulation his cold and atrophied legs had become so well developed that he could run and play with the other children, without any artificial support whatever, and has remained well until the present time, with constant improvement in the development of his lower extremities.

CASE II.—John S., of Brooklyn, aged nine, was brought to me on the 15th July, 1886, with a very marked equino-varus of the right foot, with severe contraction of the plantar fascia, standing on the ball of the great toe.

The mother says that the child was perfectly natural at birth, but that when eleven weeks old it rolled over on its face in the bed and was nearly suffocated. Two days later it had convulsions, which were repeated at intervals for two days, during which time the bowels were obstinately constipated. After forty-eight hours a passage from the bowels was effected and the convulsions ceased. Some weeks afterwards it was noticed that the child had lost full control of the muscles of the eyes, being unable to move the eyes in all directions as it formerly had done. This gradually disappeared, and when he began to sit up the mother noticed that the feet were strongly drawn backward, and the knees widely separated. When he began to stand he did so on his toes, the heels of both feet being strongly drawn upwards. Wore braces of different kinds without benefit, and when he was twenty-four months old was taken to a public institution in this city, where the surgeon divided the tendo-Achillis of either side, and succeeded in obtaining an excellent result on the left side, but the right one was very unsatisfactory.

He remained under treatment for two years after the operation, without any improvement in the right foot, and in February, 1885, he went to another institution in the city where the surgeon applied an "extension shoe," similar to the one described in the previous case.

This shoe was personally applied by the surgeon once every day from February until the 1st of May, and from May until July it was applied twice a day by the parents, but, as they state, without producing the slightest change in the position of the foot, although the traction power of the instrument was so great as to cause the child to suffer intense pain, which frequently lasted for some time after the "extension shoe" had been removed.

The parents therefore decided to try some different treatment and brought him to me on the 15th of July, 1886. On extending the foot and making pressure with the finger on the plantar fascia an instantaneous shivering of all the muscles in the body was produced. The same result followed point pressure on the tendo-Achillis when stretched, only in a much more marked degree. This shivering or tremor of the whole body is what I mean by the reflex spasm produced by point pressure on stretched tissues, and proves that those tissues are *contractured* and must necessarily be divided before any elongation can be produced.

As the case was one in which traction had been most thoroughly tested by a perfectly competent surgeon, and without any improvement according to the parents' account, I decided to cut him. I sent a request for the surgeon who had attended him to be present at the operation. At 3 P.M. of the same day, July 15, assisted by my son, Dr. L. H. Sayre, Dr. Woodbury and Dr. Develin, who administered the chloroform, I divided subcutaneously the plantar fascia and the tendo-Achillis, and *immediately* brought the foot into its normal position by considerable force, and dressed it in my usual way as before described. Only a few drops of blood were lost in the operation, but the space between the several ends of the divided tendo-Achillis was much greater than any of my previous operations.

No local or constitutional irritation of any kind followed the operation. The child slept soundly every night without opiates, and ate his meals with perfect regularity.

The bandages were never changed in the slightest degree until the 31st of July, just sixteen days after the operation, when they were removed for the first time in the presence of my son, Dr. Develin and Dr. John F. Ridlon. The wounds were all healed without the formation of a drop of pus; could flex and extend the foot, showing that the tendo-Achillis had united, and could stand erect with heel upon the floor. Left for his home that afternoon.

Aug. 6. Boy at office, foot in perfect position, but from too much exercise and the pressure of a tight-laced shoe there was a slight abrasion of the skin near the wound in the tendo-Achillis. The mother stated that he was so happy in being able to walk that he got a number of boys in the back yard with some goats, and as some of the boys had seen the lassoing by "Buffalo Bill" in the "Wild West" now performing in Staten Island, they attempted the same performance on the goats, and in this way he had hurt his heel, and finding a little moisture on his stocking she had brought him to see me. Fearing that too much motion might extend the irritation to the deeper and just newly organized tissues, I put on his stocking and applied over it a plaster-of-Paris bandage, thus immobilizing the ankle joint. When the plaster was hard I cut a finestra through the plaster and stocking on the abraded part and dusted it with iodoform.

He was able to walk without any trouble, but with no motion at the ankle.

He wore the plaster cast until the 16th of August, when I removed it and found the abrasion entirely healed, the foot in good position, and he was capable of flexing and extending it quite freely, and walked with his heel firmly on the floor.

Aug. 28, walked across the Brooklyn Bridge without assistance, a distance of half a mile or more, and can run up or down stairs without limping. Foot in natural position; requires merely time, massage, electricity and exercise to develop his atrophied muscles to make the cure complete.

—A CASE OF OVARIOTOMY AND ITS LESSON.—A. CLAYPOOL, M.D. Toledo.—On March 12th, 1886, my friend, Dr. W. T. Rowsey requested me to take professional charge of the case of Rosa K., who had some form of abdominal tumor or growth. She is 26 years of age, American, of German parentage, unmarried, and a domestic. Menstruation began at age of 16 years and had been regular till within a few months of date. Had general good health up to time of first symptoms of present trouble. Enlargement quite uniform over all the abdomen with a little more prominence over left side. No pain except in region of spleen. Dullness over whole abdomen regardless of position. Changes of posture did not change relationship of tumor. Excretions from bowels and kidneys were regular and normal.

Passed sound into uterus and found its cavity a little less than normal. There was much more fullness in left side of pelvis than on right. That there was a tumor of some kind present was a foregone conclusion, but what was its origin and nature?

The abdominal walls could not be moved over the growth and

yet it could not be ascites, from the fact that position did not change the area of dullness.

March 15th I plunged a trocar into abdomen, midway between pubes and umbilicus, and drew out several quarts of smoke colored, mucilaginous and inodorous fluid. This fluid was so thick and viscid that it would not flow through a small canula. The abdomen was somewhat flattened by the removal, but the relative position of tumor was not changed.

Gave the fluid to my partner, Dr. H. A. Chase, for a microscopical examination, which the doctor reported.

REPORT OF H. A. CHASE, M. D.—A pint bottle full of dark molasses-like liquid was submitted to me for chemical and microscopical examination. The specific gravity was found to be 1.020. The fluid deposited no sediment on standing, and I may say, in passing, that to-day there is no sediment, and no signs of decomposition in a portion of the fluid which I have kept since making the first examination. Upon boiling in a test tube, coagulation took place to such an extent, that the contents of the tube were completely solidified. Nitric acid had much the same effect; both tests showed the presence of Albumen.

A portion was boiled in a test-tube with Acetic Acid, and resulted in the same coagulation; on adding an excess of Acid, and continuing the boiling, the coagulation slowly disappeared and the fluid cleared up entirely, showing that Albumen was that known as *Par-albumen*.

Numerous specimens were submitted to a microscopical examination and the following elements were found, viz.: Crystal of cholesterin, blood corpuscles, round and crenated, fat, the so-called Bennett's corpuscles, which are believed to be epithelial cells which have undergone fatty degeneration, the Drysdale corpuscles, believed by Dr. Drysdale to be pathognomonic of ovarian tumors, and which are probably nuclei of the epithelial cells which have become fatty degenerated and columnar. Taking the consistency of the fluid into consideration, the presence of the Bennett and Drysdale corpuscles and especially of the columnar epithelium, I made the diagnosis of myxoid cystoma of the ovary.

After summing up symptoms and report of character of fluid we diagnosed "ovarian cystoma" of *left ovary*.

Requested Dr. Rowsey to furnish me with a history of the case while in his hands, which he did, and I give it in his own words. His report shows how difficult an early diagnosis may be in some cases of suspected ovarian tumor.

REPORT OF W. T. ROWSEY, M. D.—About November 15, 1885, I found Rosa — among my office patients, having called for aid in removing nausea and in restoring menstruation, which had been suppressed for two or more months. The usual catechetical ex-

amination revealed but little beyond the assurance that the girl was about 25 years of age, had an ill-defined pain about the margin of the lowest ribs on the left side, a "jumping sensation" hither and thither about the abdominal region, and that if she were not Simple Simon, she must be Simple Simon's sister. I prescribed a placebo, and bade her call again. She re-appeared at my office after an interval of a few days, and exhibited a similar condition, when I prescribed Ipecac and Bryonia. For many days her symptoms grew apace. The nausea was marked on first arising in the morning, was excited by the odors of cooking, and by perfumes of any kind. She was much annoyed by divers longings which, when indulged, brought no satisfaction. The *mammæ* grew round and full, while the areola slowly darkened. The *embonpoint* became more and more pronounced. The face became discolored with huge patches of "moth," the lips full and everted, while a panting labored respiration but added to the misery which the poor girl carried about daily. In the latter part of December she yielded to my advice and went to St. Vincent's hospital. Shortly after her removal to the hospital an examination *per vaginam* created serious doubts as to a possible pregnancy, although she admitted *coitus* on several occasions, during the latter part of September, 1885.

It would be but an idle task to tell of the remedies given during November, December, January and February. When the *similimum* was once established such remedies were given as were pointed out by the hand of the master in his *Materia Medica*. But continued failure to relieve necessitated another and more thorough examination, which was made and the sound introduced showed an empty uterus. Of course prudence had forbidden the use of the sound at an earlier date. Within two or three days a trochar was plunged through the abdominal walls below the umbilicus, and a very unique, thick, dark-brown, but not offensive fluid flowed through the canula to the amount of two gallons. Dr. Herbert A. Chase carried some of the liquid to his office for examination under the microscope. Dr. Chase quickly asserted, after the microscopic examination, that the peculiar discharge was from an ovarian cyst, and the case was handed over to Dr. Claypool for operative procedure.

We decided that the only chance for the patient was the removal of the growth. On April 8th, assisted by Drs. Barlow, Zbinden, Watts, Chase and Rowsey, I began the operation at 11.30 A. M.

Cut through the tissues, including deep fascia midway between pubes and umbilicus to the length of three inches. Under the deep fascia I came to a yellow, fatty granular looking substance tightly adhering to a fine structure beneath. What was it? I was puzzled and did not believe it was the peritoneum till I

had cut through the firm structure under it which allowed of the escape of the fluid and proved to be the main wall of the tumor. Here was a mess! The peritoneum and cyst wall so intimately adhered that it was very difficult to tell where one ended and the other began. Tried to drain fluid off through canula but could get but little to pass, as the most of it was too viscid to run.

The fingers carried into cyst came in contact with numberless other large and small cysts which gave to the fingers the exact impression of folds of intestines. Had I made a mistake and were my fingers among the intestines instead of in cyst? The inability of finding the glistening peritoneal membrane before reaching the tumor non-plussed me for the nonce, and I believe that some older operators than myself have ere now been confused by conditions in such operations that were no more complex than this. Be that as it may I lost several minutes time before I found that I could detach the yellow granular membrane from the firm tissue beneath.

On making out the true condition I enlarged the opening in tumor, passed my hand inside—had the patient rolled on her side to facilitate drainage—and thoroughly broke up the myriads of cysts and scooped out their contents. The cysts' contents varied in color and consistency from a light straw colored thin fluid, and smoke colored sticky mucilaginous fluid to a thick viscid colloid substance of white and brown color.

Now came the task of separating the adhesions between the peritoneum and tumor, and no easy task was it. I did it all with my fingers and finger-nails. Where the attachments were very strong I dug off, with my nails, portions of cyst wall and left them attached to peritoneum. As I separated the adhesions, I had to enlarge the opening in abdomen until it reached four inches above the umbilicus, or as Dr. Rowsey remarked from pubic bone to chin. Controlled hemorrhage by grasping bleeding points with catch forceps and letting them hang till bleeding stopped.

The patient bore the anæsthetic poorly, and much valuable time was lost by having to stop work every few minutes to resuscitate her. Vomiting occurred every few minutes.

By persistent effort and the aid of my valuable assistants, I at last succeeded in breaking up the last adhesion. Fortunately the viscera were not involved in the adhesions, and the pedicle was long and narrow. Imagine my surprise when tumor was lifted from its bed to find that it involved the *right ovary* instead of the left as I had supposed. The tumor spread over to the left side and dipped down into the left iliac fossa and was much larger on left side than right. The pedicle was correspondingly long and consisted of right broad ligament and fallopian tube. Tied pedicle with Staffordshire knot, cut it short and dropped severed pedicle into pelvis. It required some time to get the oozing blood stopped, but suc-

ceeded without using ligatures. In making the toilet of the peritoneum I repeatedly filled the abdomen with warm water (corrosive sublimated) and with one hand among intestines, and the other approximating the cut edges of abdominal walls, I moved the fingers among the intestines giving them a thorough washing and then removed the water with sponges. This was repeated till the water returned clear. Put in drainage tube through vaginal cul-de-sac. Closed abdomen with 15 silk sutures, applied a compress of cotton wool and bound it there with a snug fitting bandage. Time in operation two and a half hours.

The tumor was estimated to weigh upward of forty pounds. We succeeded in saving thirty-five pounds by weight, and the lost fluid was estimated to be nearly ten pounds.

I purposely omitted any mention, during my description of the operation, of all precautionary and antiseptic measures so that I might bring them together and thereby call more direct attention to them as I feel that success largely depends on such details. I am not an advocate of the Lister method because I think it a complex and clumsy procedure, and because I believe that entire success depends on the close attention to detail and absolute cleanliness.

A few days before time of operation I was given control of a well lighted and well ventilated room, which I had thoroughly cleaned and fumigated. The furniture consisted of two iron cots—so that the patient could be lifted from one to the other and bed kept fresh each day—two stands and three or four chairs. No upholstery was allowed.

The night before operation the patient was given a hot bath with plenty of soap used over abdomen. Also a large dose of castor-oil which thoroughly moved the bowels. In morning she was allowed to take only a small glass of milk, and rectum was emptied by an injection of warm water. Evacuated bladder with catheter just before beginning operation. Used sponges specially prepared by myself, in the manner recommended by Tait. Made a list of sponges and instruments used so that there could be no possibility of leaving any one in patient's abdomen. Placed instruments in a large tray and covered them with a five per cent. carbolic solution. Had assistants and myself wash our hands in a bi-chloride of mercury solution (one to one thousand). During operation had sponges washed in water and dipped in a hot solution of corrosive sublimate (one to ten thousand) and squeezed dry. Every bleeding point was quickly compressed with the catch hæmostatic forceps so that the hemorrhage was kept at the minimum. Much credit is due the gentlemen assisting me for their faithful attention to every detail.

I firmly believe that this care in all the details of an ovariectomy, together with absolute cleanliness on the part of operator,

instruments and dressing, will materially lessen the death rate in this operation. I also give credit for a modicum of the success following operation to the fact that that I tabooed the use of opium in any form.

The history subsequent to the operation is as follows :

Placed patient in bed and surrounded her with bottles of hot water, and swathed the head with dry heated flannel. Gave Hy-pericum 3x.

The lesson that I get from the case is :

First. The great difficulty, or positive uncertainty in making an early or a correct diagnosis.

Second that no case, however desperate, is hopeless.

Third. That faithful attention to details, and absolute cleanliness during and after an operation are as good if not better than Listerism.

Fourth. That opiates, if not positive injury, are at least unnecessary.

Fifth. That Homœopathic remedies, carefully selected, do materially aid in the recovery of a patient after an ovariectomy.

—ANTISEPTIC TREATMENT OF CROUP.—The following is a plan of treatment recommended by M. Renon (*Journal de Med. de Paris*): The patient is placed in a well-ventilated room of medium size, the temperature of which is maintained at from 68 degrees to 75 degrees F. Upon an oil-stove is kept a vessel, of a capacity of two quarts, in which the water is constantly boiling. Into this put, every three hours, a tablespoonful of a mixture of salicylic acid, 56 parts ; benzoic acid, 112 parts ; carbolic acid, 280 parts, and alcohol, 468 parts. The stove is placed near the bed, and the steam impregnated with this mixture is conducted, by means of suitably arranged curtains, to the patient. The patient is kept in this atmosphere until the symptoms have entirely disappeared, and for two or three days after ; and, if tracheotomy has been performed, until the wound is closed. A close watch should be maintained over the case, and if any symptoms of poisoning are manifested, the quantity of carbolic acid should be diminished.

—Dr. E. A. Lodge, the veteran editor and publisher of homœopathic medical literature, died at his son's residence in Detroit. For several years past the doctor has not enjoyed good health, and on this account was compelled to pass his winters south. As editor and publisher of the *American Observer* he became well known to the profession as an indefatigable worker, and although of late years not identified personally with the homœopathic profession in society or political work, he nevertheless had the interest of the cause at heart. Dr. Lodge leaves, as his representatives in our school, three sons, all established in practice, and they will, no doubt, see that the *Observer* is kept alive.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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No. 3.

MAY, 1887.

VOL. IX.

HOURL-GLASS CONTRACTION OF THE UTERUS DURING THE SECOND STAGE OF LABOR.

BY W. J. MARTIN, M. D., PITTSBURGH, PA.

Read before the Homœopathic Medical Society of Allegheny County.

This, I think, will be admitted is not a hackneyed subject. I never heard of it before, never read a report of any such case occurring in practice. Our text-books all treat of hour-glass contraction as a complication or difficulty that may be met with during the time allotted to the delivery of the placenta, otherwise denominated the third stage of labor. But when treating of dystocia, or the causes that render labor either difficult, impossible, or dangerous, I do not find in any of our text-books that I have had access to, consideration given to, or mention made of hour-glass contraction occurring in the second stage of labor.

That there may be no misapprehension as to what is meant by hour-glass contraction of the uterus, I will say that, "it consists in a spasmodic contraction of the internal orifice, or os, the external orifice, or os, being uncontracted or relaxed. Under these circumstances the uterine neck sometimes measures five or six inches in length and four to five in diameter the cavity of the womb proper is above the retracted part, but it seems as though the cavity of the womb is divided into two portions and the retraction, although seated at the internal orifice, seems to exist very near the middle of the uterus, which circumstance has caused many practitioners to suppose that they had encountered an irregular contraction of the body of the womb."—*Cazeaux and Tarnier* (vol. ii., p. 871).

At page 701 of this same volume, under the consideration of "obstacles at the neck of the uterus," productive of dystocia, is the following, which is the nearest to a consideration of the difficulty which was the cause of the trouble in the case to be reported, that I have been able to find :

"But it is not the external orifice alone which may retard the delivery of the foetus by retracting on its neck, for very often the internal one, or rather that portion of the uterine walls which correspond to it in the non-gravid state, retracts forcibly on the neck of the child, even before the head has cleared the external orifice, so that the latter, being retained in the portion of the organ that appertains to the neck after delivery, can advance no further.

"There is every reason to suspect that the delay in the progress of the head is dependent on this cause, when, notwithstanding the energy of the pains and the absence of all other sources of dystocia, it is found to make no advance at all, or, even if it approaches the vulvar orifice during the contraction, it returns to its primitive position immediately afterwards. Besides which, if the finger is slipped above

the head the latter will be found free in the excavation, but one of the orifices (the internal one, usually,) will be strongly retracted around the neck.

“ Under these circumstances, should version be judged necessary, the most serious difficulty may be anticipated in passing the hand through the retracted part; and if the application of the forceps be deemed requisite, as it would be if the head were already engaged, but delayed by the retraction of the internal orifice, this latter circumstance, by arresting the shoulders, would render the delivery impossible. It is then we must have recourse to the measure so much vaunted, and so often employed by Dewees with success, namely, to bleeding in the arm, pushed *ad deliquium animi*. But, in order to avoid drawing too great a quantity of blood, the patient should be directed to stand up, if possible, and as soon as fainting occurs she is to be replaced on the bed; when the relaxation in the retracted orifice, produced by the syncope, will be such that the pelvic version, or the extraction of the head by the forceps, can always be performed.

“ In cases of this kind the use of anæsthetics might prove serviceable, by producing relaxation of the partial spasm of the uterine fibres. M. Dubois has administered them with advantage, as is shown by an example given in the excellent thesis published by Dr. Tissier, on the subject (Paris Theses, 1860). In all cases chloroform should be tried before having recourse to bleeding to syncope.”

CASE.—On the afternoon of Sunday, Jan. 23, I was sent for by Dr. Gundlach to assist him in the delivery of Mrs. —, the mother of three children; previous labors perfectly normal. She was now at full term and was taken in the morning with profuse hæmorrhage from the womb, accompanied by little or no pain. She summoned a professional midwife of experience and good judgment, who at once gave her a few teaspoonful doses of fluid extract of

ergot, with the effect of subduing the hæmorrhage. Several hours after the hæmorrhage had ceased, no pain coming on, the midwife proceeded to make a digital examination and found the os externum open and one of the extremities of the child presenting, but could not determine whether it was a knee or an arm presentation. She was wise enough to send for counsel and assistance, and had Dr. Gundlach called in, who very soon made out an arm presentation. An attempt was then made by the midwife, under the instruction of Dr. G., to perform version, but she was unable to find the feet, and after persistent efforts gave it up.

At this stage I was sent for. There was no pain. The woman appeared quite comfortable. She was a strong, healthy, young German woman. After listening to a recital of the facts I have just given, I proceeded to make an examination and noted that the vagina was capacious and non-sensitive, the os patulous and well dilated, and an elbow presenting; by following up the arm the shoulder could be made out and that was all that could be felt of the child. About the arm, which was flexed, could be felt distinctly the uterine walls. And by further investigation we found that the uterine walls converged to form a firm ring which encircled the child just above the shoulder, and so tight was this constriction that it was with some difficulty that we got a finger through it and traced it around the child's shoulder and into the axilla, and made out the difficulty to be an hour-glass contraction of the uterus in the second stage of labor. The diagnosis was clear. How to proceed to deliver the woman was the question for consideration. Chloroform was decided upon as the means through which we might expect to be successful, as by it the pain which our efforts at version would cause would be obtunded and the tissues relaxed. She was accordingly profoundly anæsthetized, and lubricating my hand and arm I proceeded to introduce my hand into the cavity of the uterus

for the purpose of bringing down the feet. The constriction was more yielding than before, but ere I got my hand through it the reflex contractions were so powerful that I was obliged to desist. The chloroform was continued and the patient more profoundly put under its influence than before. On my second trial, the patient being firmly held by her husband and the midwife, while Dr. G. kept up the anæsthesia. I succeeded, after very hard work, in getting through the constriction and securing the feet, which I brought out; the delivery of the body was then easily accomplished. Next the arms were brought out, which was very difficult; the arm and shoulder that had been presenting were black. It was in the delivery of the head that we had our hardest work, for, notwithstanding the great amount of chloroform taken the constriction at the internal os persisted, and when the body was drawn through it closed tightly around the child's neck. Dr. G. with all his weight and strength pressed upon and pushed down the fundus uteri with both of his hands upon the abdomen, while I made all the traction I dared, and finally the child's head was expressed from the uterine cavity. There was a deep indentation around the calvarium as though a cord had been tied very tightly round the head.

The placenta and membranes came away at the same time as the head, and we had no further trouble. The woman made an uninterrupted good recovery. She was given *arnica* 1 in water, a dose every two hours. The next day after delivery, there was some fever and *verat. vir.* 1 in water was given, and the next day, the fever being absent, the *arnica* was resumed and continued. Vaginal injections of carbolyzed warm water were given twice a-day for five days, at the expiration of which time (the fifth day) the woman was so well that she left her bed. She has continued to be perfectly well.

A NEW TREATMENT FOR ASPHYXIA NEONATORUM.

BY E. G. H. MIESSLER, M. D., CHICAGO.

When from any cause the child is born in a state of asphyxia, no time should be lost in applying the best known means for resuscitation.

Various method of reviving the child have been recommended, and while authors agree upon general modes, they disagree to a certain extent in matters of detail.

Without entering at this time upon a statement of the various methods which have been advocated and practiced by some of our best obstetricians, and which doubtless have been effectual in many desperate cases, I wish to call the attention of the profession to a new method, which, to my mind, affords advantages over any thing heretofore recommended.

It is well known that one of the chief causes of asphyxia neonatorum is found in obstruction of the foetal circulation arising either from compression of the cord or from premature separation of the placenta. The mother breathes for the foetus in utero; and from the blood which becomes aerated in the maternal lungs the child derives its oxygen, while into the same blood passes from the child carbonic acid, and therefore, when circulation through the umbilical cord is arrested the child soon dies. Accordingly our first efforts in the treatment of the stillborn are in some way, to restore the supply of oxygen. But how can that be effected? If we inflate the child's lungs with our own breath, we offer vitiated air. Other direct means of inflection may not be at hand. The best method of all to follow, is nature's own, and in adopting it we supply oxygen from the mother through the umbilical cord. If the placenta has not already wholly separated from its uterine attachments life may be sustained for a time without reference to respiration on the part of the child. If separation has taken place the supplies

through the cord are entirely shut off. But whenever separation has not taken place as in most instances it does not immediately after delivery, let the method which we are about to suggest at once be tried, since delay may be fatal. Instruct the mother to breathe for the life of her child a few times more. Let the inspirations be deep, and with the full inflation of the lungs the vitalizing effort of the oxygen will be rapidly communicated to the living child, who lies in an easy position, close to its mother's body. How imprudent, indeed, how wrong is therefore the practice in such cases of immediately severing the umbilical cord, as recommended in some text-books and practiced by many! as the cord is that channel through which the foetus in utero receives its nourishment, the cutting of that channel under such trying circumstances would be to cut off the last spark of hope for many a child.

The new method of managing foetal asphyxia before, alluded to, was first published as a suggestive hint in the *Clinique*, in 1881.

"When from any cause the child is stillborn," reads the report then made, "be in no haste about cutting the umbilical cord, but, by all means make use of the physiological fact, that the foetus in utero breathes with its mother. To this end place the child on a warm flannel or blanket, on the bed near its mother, or let an assistant take hold of it, in such a distance as the umbilical cord will allow, then tell your patient to take a long deep breath, twice or three times, or oftener if necessary. When this is being done you will notice that the child will open its mouth widely, and simultaneously with its mother's breathing gasp for the necessary air, by which means the lungs are moved and brought into action. This of course holds good only then, when the placenta is as yet attached to the walls of the uterus, otherwise the mother's breathing would have no more influence on the child. I consider these means far better than the blowing of air into the child's mouth as

advised in our books." On pages 41, 261 and 262 of the same journal may be found reports of cases where this new method was applied with the happiest results and the still-born restored to life in a very few minutes.

But without further detail of cases under my own care, let me refer to a letter addressed to the editor of the *Clinique* in gratitude for publishing this new method, by Dr. Knox Stuart (*Clinique*, vol. iii, page 265) which reads as follows :

"DEAR EDITOR:—In reading the *Clinique* some time since, I was attracted to an article on the new method of resuscitating stillborn children. As I am very much interested in any thing concerning obstetrics and anxious to gain all useful knowledge concerning such cases, and having several times met with a great deal of trouble, loss of time, and anxiety of parents and friends, and no little anxiety to myself for fear of a stillbirth, I resolved to try the new method and I have found it the best and quickest I have ever used. I have resorted to it whenever opportunity has offered, since reading the article, and I would advise any and all who have not done so, to try it, for I do not think they would ever adopt any other method. Thanks to you and the *Clinique* for publishing the same. I have spoken to several of my friends in this city about it and all that have tried it are much pleased."

That this method is an imitation to nature's own way and directly derived from that source, on account of which it justly may be called a "natural method," no one can deny—and that the same is a new method may be proven by the first, that even men of a wide-spread practice and of ample experience in the art of obstetrics adopt the same as something new and worthy of trying. Let me mention only Dr. P. Munde, of New York, the well known author of the *American Journal of Obstetrics* and the diseases of women and children; a physician, who, not only during his many years practice in this country but also during his stay in some

lying-in-hospitals abroad (ten months in Vienna, and three years at Stuttgart) has witnessed thousands of obstetrical cases—in reply to a letter containing a copy of the article alluded to as published in the *Clinique*, writes as follows:

“DEAR DOCTOR: I am in receipt of your very interesting letter of the 27th ult. Your suggestion of the treatment of asphyxia neonatorum seems to me an excellent one. I shall certainly try it on the first occasion. I regret that you did not give your views on the subject wider publicity by publishing the paper in this journal. If you have any new experience to offer, which has not already been published, I will be happy to receive it as an original communication.”

In conclusion let me say that this is written for the mere purpose of impressing the importance of this new method upon all who may not have tried it yet that, whenever they shall meet such trying cases they might apply the same before resorting to any other method, and doing so, they will be pleased to see their efforts crowned with the very best results.

VALUE OF THE KNEELING POSTURE IN SOME CASES OF PROTRACTED LABOR.

BY DR.

Edwin M. Hale

CHICAGO.

Read before the Illinois State Homœopathic Society, in May, 1886.

Some very strange experiences might be reported, relating to the unexpected results of certain postures in labor.

Without entering into any theoretical explanation of the *modus operandi* of these postures, I propose to record a very singular result which I once obtained by means of the kneeling position.

Mrs. J— a short, fat woman: In her first labor, the progress was very slow and painful. The pains had lasted twenty-four hours before the os had dilated sufficient for the head to descend. But it did not descend, nor did it progress beyond that stage, notwithstanding the use of the hot sitz bath, the douche, caulophyllin and cimicifuga, I wasted six hours, the soft parts became hot and swollen, and the woman showed signs of severe exhaustion. The long forceps were applied but my strength was not sufficient to move the head.

At this juncture I called on Dr. Geo. A. Hall who used another kind of forceps. He succeeded after nearly an hour of forcible traction, with the aid of an assistant. The perineum was badly ruptured: was sewed up immediately, and the patient made a good recovery.

Three years after, I was called to attend the same woman in labor, with the same history. The head refused to progress, at the same point. I applied my long forceps and with the aid of the nurse the child was delivered, but again the perineum was ruptured. Dr. A. R. Jackson was immediately called in, and operated on the laceration, and again the patient made a good recovery.

Four years after, the woman was again taken in labor. The os rapidly dilated, but the head became impacted at the same spot. I was about to apply the forceps when it occurred to me to suggest to the patient to kneel down by the bed. After assuming this posture the pains immediately became more violent and expulsive. She did not have more than six or seven before she exclaimed "It is coming." I rushed to her side, and placed my hand on the perineum which I found was rapidly distending and another pain expelled the child. There was no rupture of the perineum, and she made a rapid recovery.

The question arises. If she had assumed this posture with her first labor, would the child have been born naturally?

I think not, for owing to her peculiar physical conformation I expected a lingering labor.

With the second child, the result of the kneeling posture might have been successful. I have since learned that in a fourth labor she assumed the responsibility of taking the kneeling position, at about the same stage of labor, and the child was born before any physician could be procured. I have often seen protracted labors rapidly terminated by the same procedure.

One of the most plausible explanations of arrest of labor in the second stage, is that given by Lusk. He says (page 426, Midwifery) "It is either due to exhausted nerve power, or *excessive uterine retraction*: in the latter case the withdrawal upward of the uterine muscle, and the consequent lessening of the intra-uterine pressure." He quotes Hofmeier, who reports a number of instances when the head rested on the pelvic floor, that the ring of Bande, which was made and by palpation through the abdominal parietes, was situated at from five to seven inches above the symphysis pubis, so that the contractile portion of the uterus covered not more than one third of the fœtus. Under such circumstances, while the patient suffers from intense pain, the contractions of the partially emptied uterus do not possess the force to overcome the resistance of the rigid perineum. I think I have observed several instances of this kind, when the kneeling posture caused the retraction to give way.

But in the case of Mrs. J— and some others, this could not have been the condition present, unless the contraction with retraction of the uterus occurred at an earlier stage, for the head had not descended sufficiently to press on the perineum.

In Mrs. J.'s case, and many others I have observed that while the presentation appeared normal, the head did not descend; there was no *flexion*. Perhaps this non-flexion was the cause of the arrest of labor. But why does the head

not flex? I believe it is because the expulsive force is not applied in the proper direction. Nor can it be applied while the woman is on her back, or side, or in any other position than *kneeling* with the body bent forward.

One peculiar symptom observed in these cases, is, that the vagina, which, previous to arrest of labor, seemed open enough—soon after the descent of the head was arrested, appeared to “fill up,” and the head actually seemed higher than before. This would imply that the so-called “tonic retraction” may occur before the head reaches the floor of the pelvis.

Now, while I am in favor of the use of the forceps in all such cases, in view of the apparent good effects of the kneeling posture, we ought to give it a trial.

It is singular how little mention is made by modern writers on midwifery, of the various postures which may be taken with benefit by women in labor. Lusk does not allude to a kneeling posture. Leavitt says that woman should be confined to her bed during the second stage of labor. The only authors who have treated on this subject at all, are Siebold, Engleman, and Areling.

The latter says of the advantages of this position: “It is believed by many obstetricians to be by far the best in which a woman can be placed during the last stage of parturition.” It is said to be that which women in labor naturally adopt. History certainly proves it to have been widely used in all ages and places. In this posture Homer places Latona during parturition:

“When, with her fair hand she a palm did seize,
And staying her by it, stuck her tender knees
Amid the soft mead, that did smile beneath
Her sacred labor, and the child did breathe
The air in the instant.”

This quotation graphically shows the rapidity with which labor may be terminated in this position.

Patients delivered in this position usually kneel on a pillow, with the knees apart, and the arms upon a chair, bed, or lap of an attendant. The physician takes his seat on a low ottoman on her left side, and placing his hand on the perineum, watches for the descent of the head.

There is no fear of the child being precipitated from a height with injury to itself or its mother. The space between the uterus and the pillow upon which the patient kneels is so small that the head of the fœtus is arrested before the whole of the body is expelled, and the average length of the funis is sufficient to prevent it dragging down the placenta or uterus, even if the accoucheur did not attend to the taking of the child.

Moreover, this posture is strictly scientific, for when the woman is thus placed the outlet of the pelvis rests perpendicularly and the greatest gravitory influence of the fœtal head is secured. More than this, the expulsive efforts of the woman can be exerted with far greater force and ease, than in any other position.

As the trunk of the woman is bent forward, the propelling force of the abdominal muscles are exerted at a proper angle, to best insure flexion of the fœtus through the curve of the genital canal.

If accoucheurs will carefully consider the many mechanical reasons for the use of this position during the second stage of labor, they can not fail to be convinced of its utility. It certainly ought to be tried in all cases of lingering labor in the second stage before we resort to the forceps, even if we consider ourselves perfectly skillful in the use of those instruments, for, notwithstanding their great value, there are some injuries which often follow their use even in the hands of the most expert.

UTERINE CANCER.

BY J. HENRY CARSTENS, M. D.

If we could some day find that a bacillus is the cause of cancer, and thus clear up the origin of this formidable disease, then we would soon read and write but seldom on uterine cancer. The more incurable the disease, the more we talk, read and write about it, and the larger is our list of remedies.

Cancer, it is claimed by some, is of constitutional origin; others maintain that it is a purely local disease at first. I believe that there is a hereditary predisposition to cancer in certain cases, as the family history often proves, but that, added to this, there is a local exciting cause. If we bear in mind that the uterus is involved most frequently, then in order, the breast, stomach, and rectum, in short, those organs most subject to insults, then we most naturally assume that injury has something to do with the development of cancer. In almost every case we get a history of some injury to the parts affected—received perhaps a long time before the development of malignancy—a history of a swelling, small tumor or ulcer. We also know by experience that if these tumors or ulcers are removed early no cancer develops. Whether a process of evolutions in these little knots or ulcers goes on, or some pre-naatal cells lie dormant for years and then suddenly develop into a malignant growth, I will not try to answer.

For uterine cancer I have never failed to find the nidus of the disease in a lacerated cervix, but I do not say that cancer never develops without injury, for it certainly does, as unmarried women have it. The onset of the disease, gradual at first, just as the small knot in the breast remains for years without attracting much attention, and then within a few months develops into a malignant growth, so will (after existing for years) a lacerated cervix which has not cicatrized be the starting point of cancer.

Uterine cancer is, I think, always of local origin in subjects with hereditary predisposition; and also that no constitutional treatment or local remedy has any effect on the disease. The treatment, in the presents state of our knowledge, is for early removal after diagnosis. We may operate in the late stage for the purpose of stopping the hæmorrhage and discharge, or to ease the pain, to prolong life, but not with the expectation of completely eradicating the disease.

Early diagnosis is our only hope if we want to successfully combat this disease. In every case where a woman has a laceration or ulcer, accompanied by an ichorous, bad smelling discharge, be on the look out. Cut off a small piece of the diseased tissue and examine with the microscope. If malignant, now is the time to operate. Most of the specialists see the disease in the last stage, when but little can be done. It is the general practitioner who must make the early diagnosis. One patient, operated on six years ago, after making the diagnosis as above with the microscope, has not had a return so far. It is still an open question if it is best to remove the whole uterus per vaginam, or simply scoop it out. Removal of the uterus is a very dangerous operation, and if the surrounding tissues are already involved, is of no avail. So that only in the very earliest stage would this operation be indicated, and even then it is questionable if it offers any better result than the scooping out of the uterus and leaving a mere shell. The latter is less dangerous and prolongs life probably just as much, if not more, than complete extirpation.

I notice that operators differ in the detail of their operations, but all aim at complete removal and cauterization.

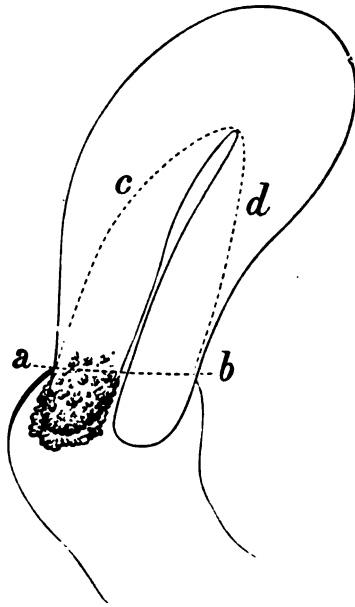
I might relate the case of Mrs. M. aged 46, mother of five children, youngest 6 years. She has had leucorrhœa off and on for years; in the early part of 1885 menstruation was prolonged and profuse, followed by an irritating and watery discharge from the vagina. She finally called on

Dr. Maire, who made the diagnosis of cancer. I was called to operate, if necessary. As I found an enlargement of the posterior lip of the cervix, and the diagnosis clear, we put the patient under chloroform and operated as follows:

With a chain *ecraseur* I removed the whole cervix up to the vaginal juncture, getting one-half inch beyond all diseased tissue. (Fig. 1, a-b.) I then grasped the uterus near the canal with the claw forceps, and with sharp-pointed scissors removed a conical piece nearly to the fundus (c-d). During the latter operation, the circular artery was cut and ligated with fine silk, which was cut short. A mere shell of the uterus only remained. The oozing was stopped by very hot water. The usual plan is to tampon with persulphate of iron solution and leave it in two days, to prevent secondary hæmorrhage, but the iron is removed with difficulty, and leaves not a raw surface for the caustic to act on, but large, hard clots in many places. I therefore carefully dried the vagina and applied to the whole mucous membrane some vaseline, which will prevent the caustic from burning the vagina. I then applied chloride of zinc solution (drachm 1 to 1 oz. water) on a pledget of cotton attached to a string, or rather a number of them, so as to fill the uterine cavity. I then took two large, *dry tampons* of absorbent cotton to fill the vagina, for the purpose of catching any caustic which might run down. I did not fill the vagina completely, as the pressure on the urethra would otherwise require the use of a catheter. The after-treatment consisted in the use of anodynes, when needed, and a mild diet. If complications arise, these are treated on general principles. Forty-eight hours after the operation, the dry tampons were first removed, then those which held the zinc chloride solution, the vagina was washed night and morning with carbolized water (2 per cent.) The bowels were moved the next day and kept regular thereafter. On the tenth day the slough came away, leaving a raw surface which soon healed, and then the uterus contracted to a small,

hard knot. Our patient was sitting up on the tenth day, and two weeks after the operation was doing most of her housework. She (as all such cases should be) was examined every three weeks, but no return of the disease has taken place so far, nearly a year after the operation, and she has gained remarkably in general health and strength. If it should return, it will be removed and cauterized as before. All patients are afterwards treated with arsenic, which is supposed to retard the disease.

In cases complicated with other diseases, and of long standing, and also implicating the surrounding organs, the drain on the system can be checked, the bad-smelling discharge stopped, the pain eased, and the patient's life prolonged and made comfortable by removing the diseased tissues and cauterizing as above described. From my experience I would draw the following conclusions:



1. The starting point of cancer is generally a lacerated cervix which has not healed; consequently all such lacerations should be repaired.

2. Early diagnosis is essential if we expect to prevent recurrence. This must be the work of the general practitioner, who frequently sees these cases first.

3. In all cases with a raw surface, and an ichorous, watery discharge, a small piece of the diseased tissue should be removed and subjected for microscopical examination for cancer cells.

4. The operation should be performed early.

The editor commends the above paper to a careful consideration on the part of his subscribers as it clearly and concisely places the subject before the profession in a manner that cannot but be appreciated by them. There is no disease in gynæcological practice that gives so little credit to the attending physician as cancer of the uterus, and none so little understood and comprehended by the people, except the dreaded name. On this account an early diagnosis is almost imperative, and a guarded prognosis given at an early date.

GYNÆCOLOGY IN GREAT BRITAIN.

BY EDWARD BLAKE, M. D., LONDON, ENGLAND.

It is curious that in the most populous city the world has ever seen, there should have been no special society devoted to the consideration of the diseases of women till the present time.

That neither London nor Edinburgh could boast of any such institutions, till many years after special societies had been formed in the States, is the more to be wondered at when we remember that Great Britain is [*pace* the shade of Récamier] the birthplace of modern gynæcology. At No. 11 Chandos Street, Cavendish Square, London, England, a few doctors met on 27th December, 1884, "to consider the necessity of forming a Gynæcological Society which should embrace Great Britain and Ireland." In this humble way commenced the British Gynæcological Society which now enrolls five hundred Fellows, and is one of the most vigorous and healthy of British medical societies.

Its origin has a peculiar interest for all concerned in the spread of the great truths of homœopathy, because this infant society appears likely to do good service in helping

to remove the disgraceful prejudices that have embittered the medical controversy.

It has already done much toward bridging over that chasm that divides rational therapy from the obsolete empiric proceedings of the past. It is fitting that woman should ever, in her physical frailty, be the messenger of peace between the rival medical armies.

A stimulus to exertion, such as emulation can perhaps alone provide, arises when a generous rivalry is conducted with courtesy and consideration. A little mutual concession makes such a rivalry possible. But not on lines like these has the great war of the creeds been waged. Its annals have been a record of shame, and the sooner they are burned, or buried, the better for the credit of a so-called liberal profession.

By a strange irony of fate the chair was taken at this preliminary meeting by Dr. Routh.

The resolution that stood fifth on the Paper of Agenda was: "That all duly qualified medical men be eligible for election as Fellows of the Society." This was duly carried, and, what is much more remarkable, it has been literally acted upon.

We can now see that the establishment of this institution marks an epoch of no small importance in the history of the homœopathic reform.

For the first time in Europe since the promulgation of the homœopathic method, men who boldly avowed their belief in the doctrine of similars were admitted into a medical society founded and framed by the dominant school. Not alone were homœopaths admitted, but they were enrolled as acknowledged practitioners of homœopathy.

Thus the late Dr. Duncan Mattison, on applying for the Fellowship of the Society, stated plainly in his application that he was in the habit of practicing the homœopathic heresy. No exception was taken on that score to his admission.

Not alone were well-known homœopaths as Dr. Philip Porter, Dr. Carfrae (Gynæcologist to the British Homœopathic Hospital), Dr. Edward Blake, Dr. Andrew Miller, and Mr. Noble, received. But the council made a vigorous stand when pressure was brought to bear on them by some influential members of the British Medical Association and by the Obstetrical Society to deny liberty of speech to the homœopathic members.

One of the Homœopathic Fellows having sent in a paper to be read, a determined effort to blacken his character and effect his expulsion was made. Instead of merely calling for a formal defence or in the more high-handed manner of old days, asking for a resignation promptly, without investigation, the Society in this case took up the cudgels for its maligned member and compelled the slanderer to withdraw his totally unfounded allegations, and to apologize both to the Society collectively, and to the member individually, under penalty of an action in the Court of Queen's Bench in case of default.

This is indeed a new departure.

The whole of the fighting for the Homœopathist was done by Alopaths.

We shall now see why the fact of the president or chairman of the preliminary meeting being Dr. Routh should be so curious a coincidence.

This is the same Dr. Routh that wrote on the Fallacies of Homœopathy, some years ago.

He is a next-door neighbor to our friend Dr. Dudgeon, and there has been a good deal of war in that district.

Dr. Routh is chiefly known to the profession as the gifted author of two publications—one on the Feeding of Babies, and the other on the Fallacies of Homœopathy.

Thus he has been a supplier of food for infants, and a purveyor of pabulum for babes more mature in years if not in general intelligence.

47 SYCAMOUR STREET, HYDE PARK.

A CASE OF HYSTERORRHAPHY.

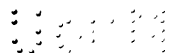
BY WM. TOD HELMUTH, M.D., NEW YORK.

(Reported by Dr. S. H. KNIGHT, House Surgeon.)

Hysterorrhaphy, as defined by Dr. Howard Kelly, is a term to designate "the suspension by suture of a viciously posed uterus. . . . Etymologically it includes all cases of operative interference in which sutures are used upon the uterus," but in its limited sense is not "intended to cover those cases in which suture of a mutilated organ forms part of another operation, as removal of myomata, etc."

During the last ten years operations of the character about to be described have occasionally been performed. In 1877, Schroeder ("Handbuch der Weiblichen Geschlechts-Organen," p. 208) reports that P. Mueller has performed laparotomy for two cases of fibroids complicated with prolapse and fastened the pedicle into the abdominal wall. He has himself, when performing ovariectomies, stitched a prolapsed uterus high up in the abdominal wound.

"In 1877, Korberlé performed laparotomy for retroflexio uteri, removed two healthy ovaries and united their stumps to the abdominal wound." (Prof. R. Olshausen, "Über Ventrale Operation bei Prolapsus and Retroversio Uteri.") In the same paper Prof. Olshausen gives an account of two operations of his own, one for prolapsus and one for retroversion. The latter case was of a married lady, 44 years, a great sufferer from headache, loss of sleep, dysmenorrhœa and great difficulty in walking. All treatment had failed. There were many adhesions and both ovaries were removed. The uterus was stitched by its cornua with silkworm gut to the abdominal wall, where its fundus could be felt six weeks after the operation. The case of prolapse was one accompanied by great suffering. All sorts of pessaries had been tried, also colporrhaphy, which was a failure, as well as obliteration of the vagina. The ligaments were stitched to



the wall by silkworm gut close to the uterine origin. The operation was a failure as the prolapse returned.

Bardenheuser, of Cologne, has done several similar operations after castration, uniting the pedicles with the abdominal walls, but they yielded and allowed the uterus to sink back.

Lawson Tait (Pathology and Treatment of Diseases of the Ovaries,) reports two cases in both of which the uterine appendages were removed and the uterus afterward sewn to the abdominal wall. In one case recovery followed; in the other a return of pain from peri-uterine inflammation.

Dr. Säger, through Dr. Kelly (*Amer. Journal Obstetrics*, Jan., 1887), gives an account of two cases. In one case the left uterine appendages, and then the right, were removed. At the second operation the uterus was lifted from its retroverted position and stitched with silver wire to the abdominal wall. Recovery was followed by a retention of the position. In the second case, there was double castration with suture of the uterus to the abdominal wall as in the first case. The anteversion remained.

Dr. Kelly himself gives an account of a case (*Amer. Journal Obstetrics*, Jan., 1887), in which vaginal oöphorectomy was performed for follicular disease of the right ovary. A year after, the fundus was stitched to the abdominal wall. The retroflexion had resisted all attempts at replacement, and it was seen at the operation that cicatricial band in the angle in the cervix prevented any restoration. The left corner was ligated at two points and two silk stitches "passed down through the uterine tissue and up into the abdominal wall through parietal peritoneum a few millimeters into subjacent tissue and out through the peritoneum again: these were then firmly tied." The uterus lost all sensitiveness and remained in position for a year, when it was dragged back by the enlarging of the tube on the right side. At the third operation, however, when the tube, full of mucoid secretion, had been removed and

the uterus replaced it remained so, and no sutures were put in.*

The case operated upon at the Helmuth House, was a married lady, age 49, who entered the hospital December 21, 1886, and gave her history as follows: In 1865, she suffered for the first time with congestion in the uterus and pain through the hips. Every movement of the bowels caused severe urging and was almost impossible without an enema. At this time, patient spent some time at a popular watering-place with no benefit. In 1868, patient went to a physician who, as she says, used caustics in the cervical canal. This treatment caused a discharge which relieved for the time, but afterwards all her symptoms were worse. In 1870, there commenced an increased pain and soreness and patient was confined to her bed. Any attempt to maintain the sitting posture was followed by severe pain, almost causing spasms. Several well known gynecologists were consulted, some of whom said that there was a uterine tumor. As there was so much trouble with the lower bowels, a well-known specialist in rectal diseases was seen who diagnosed the trouble as due to a uterine tumor the size of a large orange, combined with retroversion and a cancerous degeneration of the rectal walls. Her case was pronounced hopeless. The next seven (7) years of her life were spent, helpless, in bed or on a sofa.

At the end of this time an attempt was made to better her condition by the use of electricity. She says that the size of the tumor was reduced and the adhesions broken up to a considerable extent. After a treatment of some months she was able to sit up and perform some light duties. An attempt to cure the retroversion by use of pessaries simply increased her sufferings. The use of a weak galvanic current for a short time, by means of a sound passed into the

* In am indebted to Dr. Kelly's article in the January Number of the *American Journal of Obstetrics* for a clear resumé of the history of the operations of Hysterorrhaphy.

uterus reduced the congestion of the pelvic viscera and relieved much of her pain.

During the last two years the patient has been experiencing the change of life with an increase of her sufferings. Electricity has failed to relieve her and her nervous system is completely shattered. Patient is confined to her bed much of the time, being compelled to lie largely on her face and have her body propped with pillows and pads.

The patient has had four (4) children, three (3) before and one after the trouble began. Her courses have always been regular and not a great increase of pain. The flow has been moderate in quantity and has changed but little since the trouble began.

Before her entrance into the hospital, the patient had been on an almost exclusively meat diet with some detriment to her general condition. Preparatory treatment for the operation was at once begun. Her allowance of farinaceous food was increased and sitz-baths ordered for every other day. The uterus was raised gradually and carefully to as near normal position as possible and kept in position by tampons soaked with glycerine, or glycerine and hydratis. For remedies, Bell and Sepia were most often indicated.

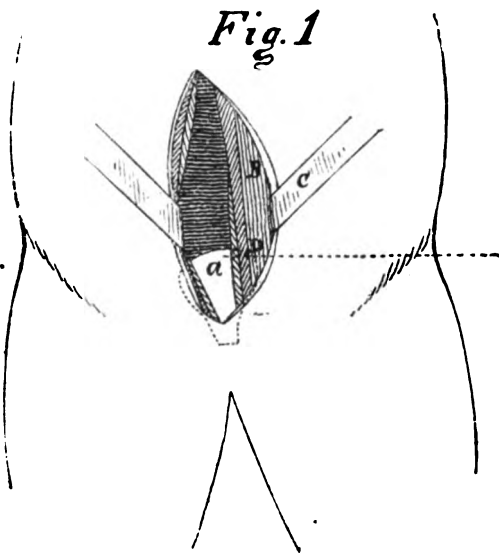
Operation, Jan. 25, 1887. An incision was made from the pubes up for about five inches in the median line. The peritoneal cavity was opened and an exploration made with the hand. Both ovaries were found atrophied and the tubes in normal condition. They were consequently not touched. The uterus was completely retroflexed, but no trace of any tumor could be seen. Posterior adhesions were found, but were broken without much difficulty. The hæmorrhage following the breaking of the adhesions was stopped by hot sponges and a little perchloride of iron solution. The uterus was now bent into position and held by forceps while the integument and fat of the abdominal were dissected away from the recti muscles and held by retractors. A No. 26 silver wire suture was now put in as follows: First, down

through the muscle then backward through the cornua of the uterus near the entrance of the fallopian tube, then up through the rectus again, and twisted. (Fig. 1.) A suture of this sort was put in on both sides and twisted tightly enough to bring the broad ligaments in contact with the abdominal walls, thus preventing the possibility of any knuckle of the intestine getting between. The twisted ends of the wires were then turned down towards the pubes. (Fig. 2.) After searching for blood in the abdominal cavity

by sponges on holders, the abdominal wound was sewn up by interrupted silver sutures and dressed with iodoform and bichloride cotton. In searching for bleeding and oozing in this operation, as in others, the electric light has been found to be of invaluable aid.

A blaze equally that of intense sunlight can by this means be thrown into the darkest corner of the abdomen.

Patient was put to bed and treated in the same way as an ordinary ovariectomy, being allowed only ice and rice-water for the first thirty-six hours. She suffered little from shock and afterwards from some twisting pains in the uterus which were relieved by Bell. Later she experienced a peculiar feeling which she described as a "bearing up." On the second morning her temperature was normal. The dressings



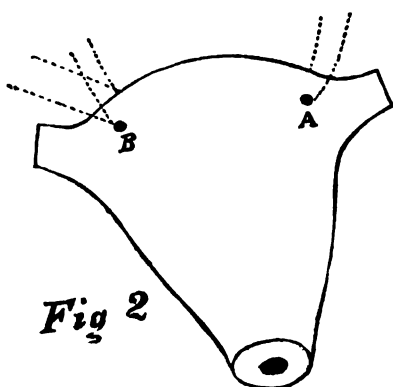
were not touched until the twelfth (12th) day when the wound was found perfectly healed and the stitches were removed. There was no interruption to her complete recovery, having no symptoms of any unpleasant nature except a little bladder irritation similar to that the writer has often noticed after abdominal sections. She was dismissed Feb-

21, declaring that she never felt better.

The fundus uteri could be felt close to the abdominal wall just above the pubes.

From a study of these cases we see that this mode of procedure is applicable to any case of retrodisplacement not amenable to other treatment, provided the adhesion can be broken,

as an independent operation or in connection with removal of a tumor or part of the pelvic viscera when it is suspected that a misplaced uterus cannot retain a normal position. We see again that fixing the pedicle into the abdominal wound or the use of silk sutures is not enough. Silver wire is needed to stand the strain. It must not be expected that bad cases of prolapse can be cured by this operation alone. The weight of the superimposed viscera will be too much for the sutures unless by some means the cervix be fixed in position and the laxity of the vaginal walls be overcome. It does not appear that any serious interference with the function of the bladder is brought about by this fixation of the uterus.



BOOK REVIEWS.

DISEASES OF THE SEXUAL ORGANS, MALE AND FEMALE. Anatomy, Normal and Morbid: Pathological and Physical Diagnosis of the diseases of those organs. Arranged in eighty full-page illustrations and one hundred and sixty pages text. By J. A. Jeanson, M.D. Published by Progress Publishing Company, Cincinnati, Ohio.

This medical work is an artistic literary masterpiece of gynecological subjects, embraced in five divisions, the first giving the anatomy and embryology of the sexual organs, male and female, ovulation, menstruation, formation of the decidua menstrualis, amenorrhœa, dysmenorrhœa, conditions of the uterus during the earliest period of gestation, croupous or fibrinous metritis, phlebitis and exudative inflammation of the uterus and its appendages, metrorrhagia, chronic hæmorrhagic endometritis, malignant tumors, and papillary, ulcerative and follicular changes of the cervix uteri.

In division two, we find diseases of the cervix continued, and puerperal metro-peritonitis, parametritis, perimetritis, oöphoritis, salpingitis, and venereal affections of the cervix uteri are taken up very exhaustively. Cancer of the uterus and sarcoma are also considered in this part with a description of the propagation into the uterus and venal pelvis.

In part three, diseases of the Fallopian tubes are concluded, and cystic tumors of the ovary, concomitant conditions of oöphoritis, pelvic-peritonitis, pelvic cellulitis, diseases of the vulva and urethra, together with displacements of the uterus complete this division.

In all parts of the work it is so complete in etiology, physical and differential diagnosis and pathology that one has but few words left with which to express the admiration due to the wonderful exactness of the illustrations. While the work is one of art as well as value, as a medical reference, we cannot but add that it is the mark of a progressive man to find the volume amidst other standard books in medicine, and we unhesitatingly pronounce it the best work on the subject of diseases of women yet out, and only hope our subscribers can afford the luxury of a set.

OXYGEN IN THERAPEUTICS. A treatise explaining the apparatus, the material and processes used in the preparation of oxygen and other gases with which it may be combined; also its administration and effects. Illustrated by clinical experience of the author and others. By C. E. EHINGER, M.D. W. A. Chatterton & Co., Chicago, Ill., 1887.

The aim of this work, to place before the profession a "hand-

book on oxygen, appears to have been well fulfilled, since we find within its pages the best methods for preparing and administering this gas. Physiologically considered, the author notes, as the effects of the inhalation of pure oxygen, a decrease in urea and uric acid, and that it stimulates the appetite, improves digestion and induces healthful and regular action of the bowels."

That part of the book relating to the use of oxygen in female disorders is meagre in details, and from the cases given, it is impossible to draw conclusions. As an accessory to treatment, it may be that oxygen with relation to general health has a sphere to fulfill, but from such evidences as is presented of its application in gynæcology, there is evidently room for improvement under the immediate supervision of specialists. Oftentimes treatments and remedies fall into disrepute by and through their application by practitioners, who do not understand the applicability, or merit of the new remedy, to diseases of the genital tract. Oxygen in gynæcological therapeutics, has, no doubt, a future, to be found acceptable to the profession if placed in the hands of those who are able to demonstrate its adaptability.

A PRACTICAL TREATISE OF OBSTETRICS. Vol. I. (In four volumes). Anatomy of the Internal and External Genitals. Physiological Phenomena (menstruation and fecundation). By H. Charpentier, M.D., Paris. Illustrated with lithographic plates and wood engravings. This is also Vol. I. of the "Cyclopædia of Obstetrics and Gynæcology" (12 Vols.), issued monthly during 1887. New York: William Wood & Co.

While the profession has had a surfeit of literature on the subject of obstetrics and gynæcology during the last year in the old school, nevertheless, "there is always room for one more on top," especially so if it be an extraordinary good work like the one under consideration. Charpentier's work is without doubt the most complete, faithful and unbiased mirror of the theories in gynæcology and obstetrics published in any language. Many of the illustrations are new and add interest to the text. The aim of the author seems to have been to present a treatise on obstetrics, which, while essentially practical, give to the student, to the practitioner and the midwife, a condensed report of all the modern researches which is, as the writer puts it, "to fill in the gaps which exist in our classical treatises."

The work is in every sense of the word, practical, and as such, will at once commend itself to our annual readers.

Vol. I. contains the anatomy, physiological phenomena, pregnancy and labor. The latter is indeed a carefully prepared treatise of confinement, care of the mother and infant during and after labor; hygiene of the infant.

A TEXT-BOOK OF PATHOLOGICAL ANATOMY AND PATHOGENESIS. By ERNST ZIEGLER. Translated and edited for English students by Donald Macalister, M.A., M.D. Three parts complete in one volume. Octavo. 1,118 pages, 289 illustrations. New York: William Wood & Company.

The increasing knowledge of morbid changes and the tendency toward the classification of diseases by arrangement as to characteristic anatomical alterations demand from our students a thorough familiarity with the subject matter of pathology. In the work now presented we recognize a superior text-book, adapted to the use of the student; for, while it can only partly replace the more extensive publications on morbid anatomy, yet there are many of the articles which, from the manner of their presentation, can be recommended as easily comprehensible by those who find it necessary to grasp, in a short course, the main features of pathology.

In the introduction the author acknowledges those functional disturbances that exclude recognizable physical changes of tissue structure, as being dependent upon malnutrition, altered metabolism, or altered relations in the environments of the cells. This promises that in those problems of life, set forth in the body of the work, full analyses will be given.

Among the prominent features we find a chapter on schizomycetes or bacteria, which includes the very latest researches. But notwithstanding the many scientists that pursue rigid investigation of these organisms, the knowledge of their vital properties, of their life, and of all their conditions, is so extremely meagre that only very few positive facts, as to their relations to cell lesions can be formulated. The closing chapters on morbid changes affecting the nervous system contain many important descriptions.

TRANSACTIONS OF THE HOMOEOPATHIC MEDICAL SOCIETY OF THE STATE OF NEW YORK, FOR THE YEAR 1887. Part I.

The transactions of any State Medical Society are, as a rule, only interesting to the individual members, therefore the disposal of printed proceedings are restricted to a few. But in examining the papers presented at the meeting of this society we find many articles of merit, of too much character to be limited to a small number. After selecting Drs. Wm. Tod Helmuth and Henry C. Houghton, of New York city, for the honor of the "Regent's Degree," which, by the way, is a fashion that would be well for other states to adopt, we are treated to the report from the "Bureau of Mental and Nervous Diseases." Daniel Lillienthal, M.D., chairman. Dr. David A. Gorton, of Brooklyn, led off with a paper on the "Observations on the Home Treatment of the

Insane." S. H. Talcott, on "The Practical Treatment of the Insane." Dr. Chas. E. Walker, of West Henrietta, on "Some Diagnostic Points in Nervous Diseases." All of these papers show careful and honest work in their construction and are above the average thesis on subjects of the above titles. Owing to meagre literature on the treatment of "Mental and Nervous Diseases" in the homœopathic school all consideration of any of these maladies will be eagerly sought by our practitioners. The report of the discussion indicate how little our members are "up" in these disorders. The Bureau of Obstetrics made a showing of more experience with this branch of medicine. Everitt Hasbrouck, M.D., of Brooklyn, was chairman. Dr. J. N. Mitchell, of Philadelphia, Pa., was present and read a paper on "A Case of Labor Obstructed by a Tumor." The chairman presented—what we regard as a valuable contribution—a thesis on "Obstetrical Memoranda and Experiences." The discussions were varied and to the point, covering some ten pages.

The report of the "Bureau of Clinical Medicine" was *chap-eroned* by Dr. H. L. Waldo of West Troy. The introductory paper was on "Drinking-Water as a Vehicle for Conveying the Germs of Disease." Dr. D. B. Whittier, of Fitchburg, Mass., a gentleman to the manor born, raised the oft-mooted hypothetical question of "Is Belladonna Prophylatic in Scarlet Fever?" Any paper from Dr. Whittier can be relied upon as of worth, not only for reading purposes, but keeping, as an item of value.

The part was completed with the reports from the three following Bureaus: Ophthalmology, C. F. Sterling, chairman (now in Detroit). Bureau of Laryngology, Geo. M. Dillon, M.D., chairman, one of the brightest lights in our school, and the Bureau of Surgery, T. D. Spencer, M.D., of Rochester, chairman. Brother M. A. Terry, of Utica, commenced the fight with "An Old Author on the Symptoms Produced by Spinal Irritation.—His Treatment.—Incidental Remarks." Dr. Terry always stamps his papers with the characteristics of progressive and vigorous thought. We await with much pleasure the publication of Part II.

ORIFICIAL SURGERY AND ITS APPLICATION TO THE TREATMENT OF CHRONIC DISEASES. By E. H. PRATT, A.M., M.D., LL.D. W. T. Keener, Chicago.

With Dr. E. H. Pratt and Rorick of our school, and the many homœopathic practitioners who were deluded into the belief that the "Brinkerhoff System" of treating rectal diseases was superior to others, there has arisen a wide-spread enthusiasm on this subject, and Dr. Pratt's little work will fill a much felt want among this class. As a brief treatise on some of the rectal disorders it will be useful to the average general practitioner, but

aside from this one feature of the work is, comparatively speaking, useless.

The gynæcological portion of the book, as a suggestion even, places the author in that open-to-criticism position that he could have avoided had he referred this part of the subject to the revision of a gynæcologist.

The therapeutics has the true ring of a homœopath. We do not belong to that branch who object to one of the "pure" employing palliatives or expedients, if it is necessary in order to hold a business, and while the author fails to enumerate remedies in detail, it is a pleasure to hear him say, "I believe that the application of remedies according to the law of *similars* involves the only scientific principle at present discovered."

The greater part of this work will please many and we bespeak for the author a hearty reception.

A COMPEND OF OBSTETRICS. By HENRY G. LANDIS, A.M., M.D. Third edition. Thoroughly revised. With new illustrations. Philadelphia : P. Blakiston, Son & Co., 1887.

As a compendium of obstetrical facts arranged for the convenience of the student this quiz-manual well deserves the cordial reception with which it meets among the undergraduates. The only point which can be criticised lies in the deficiency of therapeutical measures ; it must otherwise be classified as a standard work.

CORRESPONDENCE.

" PROVIDENCE, R. I., Feb. 25, 1887.

"DEAR DOCTOR : The Bureau of Obstetrics proposes to consider at the next session of the Institute, certain accidental complications of gestation. It is important to know the extent to which homœopathy has diminished the peril to mother and child resulting from their occurrence. To this end be kind enough to indicate the desired information in the appropriate columns opposite the names of such disases as you have chanced to meet. Under the heads of remarks, state in general, the method of treatment with the strength of the remedies employed, whether crude drugs or any given attenuation ; also any conclusions your experience has enabled you to frame. If you have not met with these difficulties please say so ; that fact of itself is of importance. The complete destitution of statistics in certain departments is an evil seriously felt by many. Will you not contribute your mite, and

thus without particular exertion on your part, unspeakably benefit the entire profession, yourself included?

"Fraternally yours,

"GEO. B. PECK, *Secretary*."

Have you ever treated pregnant women where mechanical treatment was required for the rectification of any given complication, *e. g.*, retroversion of the uterus, hernia, dislocations, fractures, etc.? State briefly nature of difficulty, periods of pregnancy, treatment, and result to mother and child.

Have you ever treated pregnant women where the knife was required for the rectification of any given complication? State compendiously the nature of the difficulties, period of pregnancy, treatment, and result to mother and child?

Have you treated pregnant women for emphysema, pleurisy, pneumonia, phthisis, endocarditis, myocarditis, pericarditis, variola, rubeola, scarletina, intermittent fever, relapsing fever, typhoid fever, typhus fever, yellow fever, cholera, epilepsy, chorea, hysteria.

Have you ever treated puerperal women for scarletina? How many? Period of pregnancy of each. Result to mothers, grouped by periods. Result to children, grouped by periods.

[With the systematic arrangement of the various subjects in the Obstetrical Bureau in the American Institute every year, we have the most complete and satisfactory study of this interesting branch of medicine that can be possibly given the profession, and especially so when the matter is thoroughly and exhaustively noticed in the medical journals throughout the country. To-day, the Institute is doing better work than any scientific body or organization in medicine, and its members should only be too proud and gratified at the results obtained by the indefatigable labor of the various bureaus with their officers. The secretary, Dr. Geo. B. Peck, of Providence, R. I., would, no doubt, be glad to receive reports from physicians who are not members of the Institute, as all would contribute to a common fund—the advancement of obstetrical science.—ED.]

Was called February 2d, 1885, to visit Mrs. H—, æt, 35, anæmic nervo-lymphatic temp. Upon examination found her condition to be as follows: For about fifteen years had suffered from gastric indigestion—sour stomach on eating anything sour or greasy—with gulping up of a sour, burning substance. Occasionally after the most simple diet, would complain of the most violent pains in stomach, from which she could obtain no relief except by the exhibition of cider-vinegar which caused eructations of gas, which partially relieved. Has been troubled with constipation and irregularity in menstruation from beginning of above described trouble. Menses often delayed six weeks and

three months and on their return causing the most excruciating pains, accompanied by strangury. Menstrual discharge, dark and clotted. Patient feels best in open air. Pains cause disposition to weep.

Examined patient with speculum, February 24th. Examination revealing extensive ulceration of ext. os uteri, also ulcerations in vaginal cul-de-sac, as also on vaginal walls. Found also ante flexion of womb for which I used McIntosh's pessary, which permanently relieved the distressing bearing down. Ulcers were touched once per day with a 2 per cent. sol. of nit. silver, which caused a rapid healing of same. For the menstrual irregularities the patient taken twice daily two drops of the ix of pulsatilla, also the same of cimicifuga rac. For the indigestion, two drops three times daily of the 2x nux. vom. Patient was directed to use water as hot as could be borne per vaginam night and morning. At the beginning of above treatment patient weighed 130 lbs. At present she weighs 175 lbs. Is troubled no more with indigestion, delayed menstruation or pyrosis, or those burning stinging pains accompanying those ulcers. Some of my brethren may find fault with the treatment, both general and local, but the result obtained was satisfactory. I believe an important adjunct in the treatment of these vaginal and uterine ulcers, is the *hot water* vaginal injections used in large quantities and repeated often. We homœopaths as a rule are too tender-footed in regard to anything *savoring of irregularity*. Would we better not use anything for the lasting benefit of our patient as well as for our own aggrandizement that will secure the desired result. Better do this than let our cases pass into the hands of those who are our common enemies in a medical sense.

BURNT PRAIRIE, ILL.

R. M. FUNKHOUSER, M.D.

ABSTRACTS.

—KALI PHOSPHORICUM IN PARTURITION.—In the *Leipziger Populare Zeitschrift für Homœopathie* Dr. Rosas commends this drug with other preparations of phosphorus as follows: "For three years I have used in my obstetrical practice, as a parturifacient, kali phosphoricum exclusively; the 4th centesimal, a quantity as large as a bean, dry on the tongue every ten or fifteen minutes. I can affirm that it never deserts me and also that I have very seldom been compelled to give the third dose. . . . I have happily consummated over ninety deliveries in the last six years without the use of the forceps. Magnesium phosphorica has also proved of much service in spasms and eclampsia.

"I have now adopted the habit of giving, directly after every delivery fernun phosphoricum in order to prevent inflammatory actions."

—AMMONIUM CARBONICUM.—Dr. Henry M. Dearborn, in the *North American Journal of Homœopathy*, includes in the therapeutical uses of ammonium carbonicum, *dysmenorrhœa*, *menorrhagia* and *leucorrhœa*, not dependent upon local conditions alone, but having systemic depression, poor quality of blood, favoring hæmorrhages, menses premature and too free, sometimes with bleeding from the rectum, cholera-like colic before and with the flow, and whitish leucorrhœa between the menses."

—EXTRACT OF HEMLOCK IN THE TREATMENT OF INTRA-UTERINE INFLAMMATION AND PASSIVE HÆMORRHAGES.—In the following cases this remedy was used as a local application to the uterine mucous membrane, after the failure of tampons, for uterine hæmorrhage.

Case 1.—A vigorous woman, forty-five years of age, who frequently boasted that she had never required the services of a physician except at the birth of her children, began to suffer from menorrhagia as the menopause approached. We saw her on one of these occasions after the flow had continued copiously for about a week; at this time it had lost the appearance of menstrual fluid and assumed that of thin, red blood. As the patient began to be anæmic, we applied the tampon daily during the next three days. The hæmorrhage was controlled as long as it was in position, but as soon as it was removed, the blood reappeared and did not cease until the inside of the uterus was swabbed out with the extract in full strength.

Case 2.—A lady aged thirty-five years, the mother of two children, began to suffer from profuse menstruation, which gradually increased month after month until it became a menorrhagia so copious that her life was saved on several occasions only by the diligent use of the tampon. This resource practically failed, as the hæmorrhage returned shortly after the tampon was removed. The bleeding was, however, controlled by the use of the extract applied in full strength freely to the bleeding surface. At the next menstrual period the normal discharge was again followed by copious hæmorrhage. We then examined the inside of the uterus, and discovered a small polypus, which we removed, with the result of obtaining a complete and lasting cure. This case forcibly illustrates the power of this *extract of hemlock* over passive uterine hæmorrhages.

Case 3.—A married lady, twenty-six years of age, called me to attend her during a threatened abortion at the third month of

pregnancy. She stated that this condition was brought about by herself, she having voluntarily taking some drug for that purpose. We found the loss of the ovum to be inevitable, and delivered her safely. The hæmorrhage was not severe, and ceased without the use of local measures, and she made a good recovery. Menstruation began in about forty days, but instead of ceasing at the usual time, it became a copious hæmorrhage. We did not lose time by resorting to the tampon, but immediately applied this valuable astringent freely to the inside of the uterus, when the blood ceased to flow forthwith.

In many cases of uterine hæmorrhage the advantages obtained by the use of this preparation over other remedies—the tampon included—are obvious. After the application of the latter the hæmorrhage always continues from the bleeding surfaces until the uterus is filled with blood, which, when it has coagulated, opposes further hæmorrhage, if the blood does not unfortunately pass along the fallopian tubes to the peritoneum. But when the loss of the vital fluid is checked by the use of the preparation here recommended, the blood ceases to flow immediately. The danger of producing a pelvic hæmatocele, and the annoyance to the patient of a tampon in the vagina, are both avoided, in addition to the lasting tonic influence of the treatment on the spongy mucous membrane.—*Provinc. Med. Jour.*

—OPERATION FOR LACERATED PERINEUM.—In the *Journal of the American Medical Association*, Dr. H. O. Marcy, Boston, contributed an article on "The Restoration of the Perineum by a New Method." This operation is so often required and is so difficult to bring to a satisfactory result, that I will venture a few words concerning the "new method" of treatment. Dr. Marcy has certainly made a great advance in the surgery of the perineum by the discovery of his method, and is entitled to great credit. The operation performed with silk, wire sutures or catgut seems very inferior to the firm pins used by Dr. Marcy. I cannot do better than to quote some of Dr. Marcy's paper:

"The use of the interrupted stitch is almost universal, no matter in what other manner the operation may vary. To this I have long attributed in a very large share the defective results, and have thought it might be remedied by the complete and careful approximation of the edges of the divided or refreshed surfaces. However, this allows a possible separation of the parts, with retention of fluid and consequent failure. The stitch may be taken so loosely as not to draw upon the enclosed portion, and not lessen the depth of the triangle, but in this instance the tension is so little there is great liability to lateral separation and imperfect union. The end theoretically to be attained is simply

approximation and retention, which complete rest of the parts, without compression or distortion. This can never be secured by the ordinary loop of the stitch, since the force applied *must* act equally in every direction upon the enclosed portion. This is evidently true, no matter what the material used, iron or silver wire not excepted, when sufficiently plastic or yielding to accommodate itself to the surrounding parts. In homely illustration, it is the string to the bag, the opening to which is narrowed or occluded, dependent upon the tensile force applied. This is as self-evident in the stitch as in the ligature, except in the degree to which the construction is carried. Other causes of defective results, usually very little emphasized, lie in imperfect approximation of the edges of the rent or refreshed parts, lack of care in the



protection of the wound from the vaginal secretions, and the direction almost universally given to the patient to restrain the action of the bowels for a considerable number of days, or until the repair processes are quite advanced."

The great difficulty in using Dr. Marcy's pins is that in locking, the points constantly slip out of the loops and threaten to do so even after introduction. To place them in position successfully *they must be bent and afterward* straightened. With my pins there is no danger of wounding the vaginal walls after the operation is concluded, and the outside points are carefully protected by the split shotguards. The pins must be introduced from within the vagina and forced outward and then secured.

After the union has so far advanced that the pins can be removed, the upper portion in the vagina should be cut off, and the ends drawn out slowly and carefully. A pair of sharp, curved scissors and a pair of dressing forceps are all that is necessary, and this part of the operation can be finished in a few moments.

These pins, and especially the pair illustrated, afford the best means for that "complete and careful approximation" which Dr. Marcy has demonstrated is the important factor to make the operation for the restoration of the perineum a success. Messrs. Tiemann & Co. have made for me the pins which seem to me an improvement on those devised by Dr. Marcy. They are respectfully submitted to the profession for examination.

W. THORNTON PARKER, M. D.

Newport, R. I., Sept. 24, 1886.

The above "perineal pins" will be fully appreciated when we real-

ize how essential it is to close up a lacerated perineum before leaving the house after a confinement. The subject is of so great importance that the operation is now placed upon the card of "rules and regulations" of the hospitals, ordered by the Board of Trustees, as one of the standing rules. If the profession only knew how much suffering they could save our poor women they would examine every case after confinement and correct any laceration, however slight, they found. The time to operate is immediately after the child is born, as the parts are numb and but little pain is complained of by the patient.

—**SYPHILIS IN PREGNANCY.**—A series of very remarkable clinical observations on syphilis in pregnancy have recently been made by M. Hiriogoyen, at the Maternity Hospital in Bordeaux, from which he concludes that, from an obstetric point of view, both abortion and natural labor take place in syphilitic patients exactly as in healthy women. In certain exceptional cases, however, difficulties attributable to syphilis may arise, such as hæmorrhage from partial adherence of the placenta, rigidity of the os, etc. Finally, women suffering from primary or secondary syphilitic lesions in the genital organs are rather predisposed to puerperal accidents, and require more attention on the part of the attendant than other women. The following is a summary of the observations, which extended over a period of two years: 1. In the lying-in wards, in Bordeaux, the proportion of syphilitic to other patients was 5 per cent. 2. Five-sixths of them were unmarried. 3. Syphilis in a pregnant woman tends to bring about premature labor. 4. The duration of the disease seemed to have a very decided influence. 5. In eight cases of pregnancy in syphilitic women who had had the disease for one or more years, only two children were born alive, and these were very puny. 6. In twelve cases, in which the mother had contracted the disease during the first four months of pregnancy, the fœtus was in every case stillborn. 7. When the mothers had become affected between the fourth and the sixth months of pregnancy, the fœtus died in about half of the cases. 8. When syphilis had been contracted during the three last months of gestation, the proportion of living children was a little more than one-half—four out of seven. 9. Out of thirty-three cases of pregnancy in syphilitic women, living children were born in eight. 10. Syphilis may give rise to difficulties during labor, and also to subsequent complications, but this is rare. 11. To be effectual, antisyphilitic treatment should be administered from the very beginning of pregnancy, and continued throughout. The treatment should be perseveringly carried out, in order to prevent accidents in future pregnancies.—*Brit. Med. Jour.*, Feb. 19, '87.

TREATMENT OF CROUP IN INDIA.—From a monograph on "Croup: Its Nature and Homœopathic Treatment," by Hurro Nauth Roy, L. M. S., Calcutta, may be learned that this disease of late is becoming common and frequent in all parts of India, and that through the superiority of homœopathic treatment more converts have been won to "*similia similibus curantur*" than in any other way. The two principal remedies used by the author are Aconite and Hepar, supplementary remedies, spongia, kaolin, iodine, bromine, phosphorus, bryonai, cuprum metallicum, antim. tartc., moschus, sambucus, kali bichromicum, arsenicum, sanguinaria, cinnabaris and acetic acid. Of the indigenous drugs used with success the following brief abstract contains those of importance:

Blatta Orient.—The insect is macerated in water, and then boiled for half an hour. In several parts of Bengal, a teaspoonful of this preparation every 15, 20 minutes, half an hour, or an hour according to circumstances. I have, however, prepared an alcoholic tincture of the insect, and used generally the 3rd dilution prepared from the same tincture with uniform success. I used the 3rd dilution on three occasions,—twice in my own village at Mohiarae, and once at Calcutta, and in all the three cases, I was successful beyond my expectation. It appears to me to act as a sedative on the vagus and laryngeal nerves. When the dyspnoea is very great, the patient's countenance is suffused with blood, and when there is restlessness with hoarseness and croupy cough, and constant change of position, *Blatta* is indicated. Only one case was characterized by febrile symptoms, the other two cases were perfectly free from fever. I was in the habit of using this *Blatta Orient* in cases of spasmodic asthma, and generally with success.

In croup, *Blatta* should be given every 10, 15, 20 or 30 minutes, according to the urgency of the symptoms. I have found after the exhibition of four, or five doses, at the most, the disease yielded, when I commenced to administer the medicine every 2 hours, and in 12 to 14 hours, not a vestige of the disease remained visible.

Mocta-Jhoree.—(*Acalypha Indica*) Nat. Ord., Euphorbiacæ. It is the second of the indigenous group of remedies. The expressed juice from the green leaves is used in Bengal, and in other parts of India, as a specific in the treatment of croup. Its action is analogous to and isomeric with the action of antim. tart. I generally use the tincture prepared from the fresh leaves, and my dose is generally from one to five drops. Only in one case, I used the third dilution and with success. In constipation of children, it is also used as a local application to the anal orifice. The leaves are pounded, made into a pulp, and applied. It

relaxes the sphincter and the muscular fibres of the lower portion of the rectum, and relieves constipation *pro tem*. Whether after subduing the spasm of the sphincter, and the muscular fibres of the lower portion of the rectum, it promotes peristaltic action, is an open question, but its application is invariably attended with a stool. Hence it is evident, that it not only subdues spasm of the local muscles, but induces peristaltic action as well. It does not generally happen that fecal accumulations lie pent up always in the lower portion of the rectum, owing to inertia, or simple spasm of the local muscles; the accumulations might, and do remain higher up in the transverse or upper portion of the descending colon, and when experience has proved to a certainty, that the local application of the pounded leaves of Moocta-Jhoree has always produced a stool, it stands to reason, that Moocta-Jhoree is not only a local antispasmodic, but it excites peristaltic action as well.

Toolsee.—(*Ocimum Villosum* or *Sanctorum*) Nat. Ord., Labiatae. Its action is analogous to the action of *hepar sulphuris*. The expressed juice of the green leaves is used in several parts of Bengal. It dissolves the thick tenacious phlegm which causes rattling and anxiety and suffocative symptoms. After the administration of the juice the child throws up large quantities of mucus and phlegm and feels relieved. It, like *hepar sulphuris*, promotes absorption of the mucus, and effects a speedy cure. I generally use the tincture with good affect. Dose, 10 to 20 drops.

Beetle-Leaf.—(*Piper chavica* or *chavica betel*). Nat. Ord., Piperaceae. It is the fourth of the group of indigenous remedies. Its action is isomeric with the action of toolsee. The expressed juice of the green leaves is used in some parts of Bengal and in other parts of India. I use the tincture, and its dose is also from 10 to 20 drops. I believe it will act more efficaciously in the third or sixth dilution.

Kala.—(*Cardanthera triflora*, or *ruellia triflora*, roxb.), Nat. Ord., Acanthaceae. It is the fifth of the group of indigenous remedies, and is found in profusion in those places where snakes abound. It is held in good repute as a *specific* for snake-bite, and I am an eye-witness to two cases of cobra-bites rallying after the administration of this plant. I cannot, however vouch whether they were deadly bites, but the patients were comatose and discolored after the bite, with injected eyes and labored breathing. Those who have taken up the subject of Indian snakes ought to give this medicine a trial. It is also a very valuable medicine in gangrene, both idiopathic and traumatic, phagedæna, bed-sores, and carbuncles, in low fevers, when vital prostration is extreme, and in other adynamic states of the system. The

expressed juice of the green leaves is used in Bengal. Doses from one to two drops. Vehicle, water or milk.

"I have used it with great success in the treatment of croup. Its action is analogous to the action of *Blatta Orient*. I use sometimes the third, and sometimes the sixth dilution."

—THE OAKUM PESSARY, BY W. T. PARKER, M. D., NEWPORT
—At a meeting of the New York Obstetrical Society held November 5, 1878, I reported the excellent results which followed the use of the oakum or marine-lint pessary. Several of the members then present expressed their appreciation of this excellent dressing, and kindly endorsed the suggestion. At the June (1886) meeting of the Boston Gynecological Society, I exhibited specimens of the excellent marine-lint made by Grosvenor and Richards, of Boston, and reported the very gratifying results following my use of this pessary in gynecology for the past eight years. Marine lint or refined oakum is a surgical dressing of great value, and it was only after witnessing the success attending its use in surgery, that it occurred to me that it might be useful in gynecology.

There are many cases in ordinary office practice where no better treatment can be adopted than the use of the oakum pessary.

For prolapsed and sensitive ovaries, for the treatment of prolapsed uterus, for many forms of misplacement, and in cases of leucorrhœa marine lint is much preferable to absorbent cotton, and keeps sweeter and cleaner longer than any other appliance. The support it affords and the sense of comfort it induces, makes it very acceptable to patients. I apply it always in a ring form, introducing it through the speculum. Where a large pessary is indicated, as in prolapsed uterus, it must be introduced without the speculum. The oakum never irritates and is always free from the odor following the use of any other pessary or of absorbent cotton. A cotton plug and cocoa butter suppository make a most undesirable application in the treatment of "uterine cases." The oakum pessary not only absorbs and disinfects the vaginal secretions, but does not lose its place, and continues to afford support until removed. This is not the case with absorbent cotton, which is very objectionable in most instances. In cases of anteversion or retroversion as well as in cases of prolapse, the oakum pessary will be found superior to the hard or soft rubber pessary. The oakum is not only an excellent support but possesses healing properties when applied to the diseased mucous membrane of the vagina. I usually saturate the oakum pessary with *boracine* manufactured by Messrs. T. Metcalf & Co., Boston, Mass. This improves the wholesome action of the pessary and permits its being retained for a much longer time. [The editor has employed

the marine-lint in place of cotton for several years and can endorse all that is claimed in the above.]

—THE UTERINE MUCOUS MEMBRANE.—Dr. Theodore Wyder, of Zürich, criticises the observations of others upon the uterine mucous membrane during menstruation, claiming that those changes, due to disease and post-mortem results have been confounded with those due to physiological effects. In his observations on nine healthy menstruating women, his experiments were conducted as follows: "During menstruation a speculum, not oiled, was passed, and the blood and mucus oozing from the cervical canal were collected with a glass rod or a syringe, neither instrument being oiled, and care being taken not to let it enter the cervical canal lest any cervical structures should be accidentally detached. The blood and mucus thus procured were examined microscopically. He comes to the following conclusions: 1. During menstruation a part of the superficial layer of mucous membrane is destroyed, while the rest persists. This removal of mucous membrane takes place to a different degree in different cases, sometimes being complete, sometimes minimal. The separated layer in part retains its structure, in part is broken up into detritus, in some cases small bits of mucous membrane, in structure like the membranes of dysmenorrhœa membranacea, but causing no pain on account of their smallness, being found in the menstrual discharge. 2. The separation is a consequence of the menstrual hæmorrhage, and not of primary fatty degeneration. This latter is rather a consequence of the detachment and breaking up of the mucous membrane effected by the bleeding. 3. The superficial and middle layers of the remaining mucosa are composed of small cells, and have no resemblance to the decidua of pregnancy; while in the deeper layers there is a cellular hyperplasia of the interglandular tissue plainly intended to reproduce the tissue cast off during menstruation. The regeneration of superficial epithelium takes place both from the glandular epithelium, and from the larger or smaller islets of superficial epithelium that may remain." —*Zeitschrift für Geburtshülfe und Gynakologie*.

—THE DIAGNOSTIC VALUE OF THE PHOSPHATES IN PREGNANCY.—This is the subject of an illustrated paper read before a recent meeting of the Richmond Medical and Surgical Society by Dr. William B. Gray. The central object is to demonstrate that the phosphates are largely *increased* during the pregnant state, and that the normal triple phosphate undergoes a peculiar metamorphosis, shown by the microscope to be the *loss of its feathery outline*.

The author began by stating that phosphorus is the great cere-

bro-spinal food or fuel, and that the amount of fuel consumed determines the amount of ashes consequent thereupon, and that therefore the amount of phosphates found in the urine must be taken as an index of the amount of fuel consumed by cerebro-spinal activities. Hence it is that they are largely increased in all hyper-taxations of this system, whether the result of diseased con-



Figure 1.



Figure 2.

ditions of these centers or their unusual physiological exercise. Neurasthenia and many cerebral troubles as also the tense mental strain of literary men were cited as examples. When the expenditure exceeds the daily replenishing, then cerebro-spinal hunger is necessarily inaugurated, as evidenced by odontalgia, otalgia and other nervous manifestations so common in pregnancy. These



Figure 3.



Figure 4.

are attributed to the large deflection of phosphorus from the mother's wants, and its appropriation to, and consumption in, the maturation and building of the foetus. While this is going on the parent furnaces are starving for food and fuel, and they raise their voices for support.

The normal amount of phosphates excreted by a healthy person, free from extraordinary physiological influences, is found to be

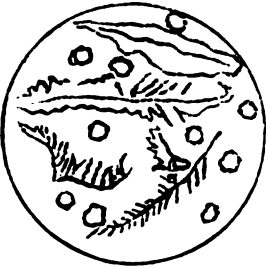


Figure 5.



Figure 6.

about fifty-nine grains during the twenty-four hours, or stated in another way, one-sixth of a grain to the fluid drachm of urine.



Figure 7.

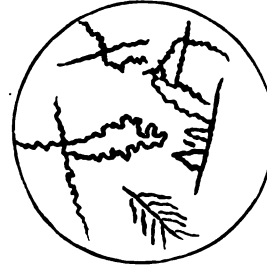


Figure 8.

To substantiate the claim that the phosphates are increased during pregnancy, fifty-four analyses of the urine of pregnant women



Figure 9.



Figure 10.

were presented. Of these, the smallest amount of phosphates found in one drachm of urine was one-third of a grain, and the

largest two and one-half grains. The latter was from a consumptive patient. The analyses referred to represented twenty-four patients. It should be stated that while the daily amount was found to be in excess of the normal quantity in all the cases examined, it appears that the increase is not regularly progressive as gestation advances.

The microscopic changes were illustrated by a large number of plates, some of which are found below. The normal triple phosphate is represented by figure 1. Within twenty days after conception it is claimed that the *feathery* portion begins to disintegrate as shown by figure 2.

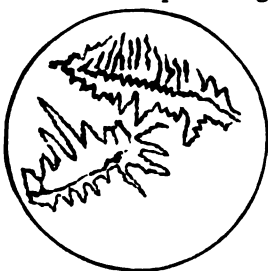


Figure 11.

The following eight figures represent the phosphates at different stages of gestation. Fig. 3, at 60 days; Fig. 4, at 90 days; Fig. 5, at 134 days; Fig. 6, at 150 days; Fig. 7, at 182 days; Fig. 8, at 212 days; Fig. 9, 242 days; and Fig. 10, at 272 days.

Past the middle of the seventh month the phosphates begin somewhat to approximate their pristine form and general character (see Fig. 9), and at the *accouchement* they can scarcely be differentiated from the normal (see Fig. 10).

Dr. Gray has also found that when the fœtus perishes during gestation, the phosphates at once recover their normal character.

To complete the comparison, Fig. 11 is from the same patient thirty days after delivery, while she is nursing.

—ON VAGINISMUS. *—G. Granville Bantock, M. D., surgeon to the Samaritan Free Hospital.

Just a quarter of a century ago, *viz.*, on November 6, 1861, the late Dr. Marion Sims read a paper on vaginismus before the Obstetrical Society of London. We read therein that when the patient who furnished him with his theme first consulted him, he had in vain searched among the authorities of that time for some guidance in the treatment of the case. The patient was a lady forty-five years of age, whose case had baffled "the most eminent surgeons in the principal capitals of America," and who "had subsequently visited London, Paris, and other European centres of learning," but in vain. She had been married for twenty-five years, and during that time "had remained a virgin," owing to the impossibility of consummating the marriage. Suffice it to say that it took Dr. Sims two years and a quarter to cure his patient.

* Read before the British Gynæcological Society.

After much failure and disappointment he at last devised a method which in its principle has since become general, and is easy, safe, and certain. That principle was to overcome muscular spasm.

Dr. Sims defines this condition as "an involuntary spasmodic closure of the mouth of the vagina, attended with such excessive supersensitiveness as to form a complete barrier to coitus," and he aptly compared it to the involuntary, painful, spasmodic closure of the eyelids when the eye is intolerant to light under the inflammatory process. This, then, indicates a reflex action, and, as in the cases I am about to relate, was not due to the presence of "inflammation of the follicles of the vulva," referred to by Dr. Oldham in the discussion, nor to the presence of sensitive papillæ spoken of by Dr. Braxton Hicks. Sims's explanation appears to be now generally adopted, and is, I believe, the correct one.

I shall now proceed to the narration of several cases of a typical character.

1. The first is that of a lady aged 29, who consulted me in May, 1884. She was generally out of health, suffered from dysmenorrhœa for twenty-four hours of the period, and had a great deal of leucorrhœa. I found it very difficult to introduce my index finger, owing to the intense spasm of the vaginal sphincter. Once in, I forcibly dilated the orifice, and managed to introduce my smallest sized Neugebauer speculum, when there were to be seen extensive excoriation of the circle of the os, with an extension forwards on the anterior aspect of the cervix as large as a shilling, and a copious glairy discharge issuing from the os, presenting a muco-purulent appearance in the vagina. The patient was a delicate, timid woman, and forbore to mention a fact, which was subsequently communicated to me by her sister-in-law, *viz.*, that marriage had never been consummated. This I assumed. But I always refrained from offending the modesty of patients, except it be absolutely necessary. I had determined to proceed with the treatment in the belief that this difficulty would right itself with the cure of the patient. It was not, however, till July 4 that I was able to begin the treatment in earnest; for which purpose the patient came to town. Sims' dilators were introduced for an hour or two twice daily, as the patient could bear it; the size was gradually increased; and when the dilator was removed the hot douche was freely used. Within three weeks the vagina was fully dilated. But it was several months before the excoriation was got rid of, and the dysmenorrhœa, together with the leucorrhœa caused by the use of bougies, carbolic acid, iodine, etc. During this time I interdicted any attempts at sexual intercourse, but at the end of March, 1885, I was able to pronounce her condition quite satisfactory, and I withdrew my interdict. In a month or

two she became pregnant, and in due course had a very favorable confinement.

2. The second case is that of a lady, aged 32, of great physical activity and good muscular development, who consulted me on June 18, 1884. She had been married a year, and, unlike the first patient, at once stated her trouble. All attempts at the consummation of marriage had proved unavailing. Menstruation was regular, with a rather abundant flow and some clots, lasting five to six days, and a great deal of pain the first two days. The vaginal orifice was extremely rigid, and at first I thought I should be obliged to resort to incision. After a few days' use of the dilators I was able to introduce my second sized Neugebauer, and then found intense congestion of the cervix and vagina, with a copious glairy discharge issuing from the os. In this case I was obliged to resort to depletion in addition to the use of bougies and the hot douche. On August 5 she returned home and sexual relations were at once established, proving that the difficulty had been completely removed. She came to town on March 11, 1885, and I was then able to pronounce her about four months pregnant. She was, moreover, in excellent health, and in due time gave birth to a son and heir.

These two cases resembled one another very much, and it is evident that in both the exciting cause was the uterine congestion.

3. The third case is that of a married woman aged 45, who consulted me on January 28, 1882. She was the mother of two children, aged 17 and 23 years, was a widow for nine to ten years, and had been married again for five to six years. Had suffered for about five years from leucorrhœa, pelvic discomfort, painful micturition, and gradually increasing vaginismus. Moreover, she was very much out of health and looked ill, was nervous and irritable. The vaginal orifice was very rigid, there was a copious mucopurulent discharge in the vagina, and the uterus was retroverted. On emptying the bladder the urine was found to be perfectly healthy. I dilated the vagina as much as I could, introduced a No. 7 Hodge's pessary, recommended the use of the hot douche, and gave her a saline aperient chalybeate. Under the treatment the symptoms gradually disappeared. She wore the instrument for about a year, and when I last saw her a few weeks ago, accompanying another patient, she was in perfect health in every respect.

4. The fourth case is one of great interest, inasmuch as the patient was operated on by Dr. Sims in his usual way, a few months before his death. She is a very intellectual lady, about thirty years old. For many years she had suffered from dysmenorrhœa, for which she had not undergone any treatment beyond the placebos of physicians, and by the time she first came

under the care of Dr. Sims it had become of the most aggravated character. Dr. Sims first divided the cervix under ether and he told me it was the most severe case of constriction he had ever encountered, the tissues creaking under the knife like gristle. Shortly afterward he introduced a stem, also under ether; but taking it out a month afterward, and desiring to replace it after the next period, which I may remark was quite painless, he found it impossible to do so owing to the amount of vaginal spasm. He accordingly performed his usual operation, and it was about a month or two after this that the patient first came under my observation. About three months later she was committed to my care. An attempt to examine her had to be given up on account of the vaginismus. Under chloroform I found that the constriction had returned to such an extent that a No. 6 bougie passed through the internal os with great difficulty, and in order to introduce a No. 10 I had to fix the uterus by means of a vulsellæ. So firmly was it held that when I wished to withdraw it I had to push against the cervix to prevent too much downward traction on the uterus. It is needless to say that by this time the dysmenorrhœa was as bad as ever. It was impossible at that time to carry on the treatment for more than two months; but the patient returned about six months afterward. Under the necessary manipulations for the treatment of the dysmenorrhœa the vaginismus almost disappeared. The patient was considerably benefited when the treatment was again interrupted. She relapsed and finally she ended by having her uterine appendages removed at own request, and I regret to say that her condition now, thirteen months after this operation, is most unsatisfactory. [Proving another of those cases where the poor woman wishes there had been no such method as Battey's operation. The removal of the ovaries as a therapeutical procedure necessarily occupies a field which is becoming more limited with the careful analysis of the results of such cases. Such serious inaccuracy as Dr. Battey displays in advising the performance of this operation, the removal of ovaries which are not diseased, "merely to bring about the menopause," can only be combated by careful individualization.—ED.] True she got rid of her dysmenorrhœa, but her nervous system is completely shattered, and is very much worse than when she passed from under my care. It is of great interest to observe that in this case the vaginismus appeared to keep pace with the degree of uterine congestion.

5. The fifth case is that of a married woman, aged thirty-two, the mother of one child, and who was brought to me on March 14, 1882, by the third case. After the birth of her child, eighteen months ago, she complained of pain on the resumption of sexual relations, and they had now become impossible. Even sitting

was painful. On examination there was considerable congestion of the vagina and cervix, with some leucorrhœa; the uterus was in its normal position. There was great rigidity of the vaginal orifice. I introduced one finger and dilated forcibly, then two, and then three fingers, and stretched it to its fullest extent, and then it was interesting to note that after overcoming the initial spasm there was comparatively little pain. The further treatment consisted of a saline aperient chalybeate, the hot douche, and a repetition of the dilatation. The patient called upon me March 22, 1884, and announced that the vaginismus had totally disappeared, and that she was then in perfect health, with the exception of a small nodule on the left breast, which was painful a few days before the period. I have not heard of her since.

6. The sixth and last case I shall relate belongs to a different class, and the cause was more mechanical. It stands No. 9 in my little work on the "Use and Abuse of Pessaries." The case is shortly as follows:

Mrs. C., aged twenty-four, consulted me on September 27, 1881. There was some vaginismus when first married, yet she became pregnant within two months and was confined on April 24, 1881. On resumption of marital relations the same difficulty was experienced; but instead of decreasing, it went on increasing until intercourse became almost impossible not only to the patient but also to her husband. There was very great rigidity of the vaginal orifice, the uterus was retroverted, and the rectum loaded. I at once forcibly dilated the vagina, first with one finger, then with two, and then with three, and the three fingers gave her less pain than the introduction of the one. I sent her home with instructions for the clearing out of the rectum. A week later I dilated her again and introduced a No. 6 Hodge's pessary of Britannia metal. By November 22 the vaginismus was "nothing to speak of," and on January 10, 1882, her husband accompanied her to tell me how satisfactory the treatment had proved. No other treatment than that by the pessary and the regulation of the bowels had been used, and on March 21 she was evidently pregnant and in excellent health.

I have very little to add. While a minor degree of vaginismus is very common and passes away under the manipulations necessary for the treatment of the associated condition of the uterus, the more severe form of the disease, causing special symptoms and requiring particular treatment, is not common. This condition appears to me to be essentially of reflex origin. In none of the cases that have come under my observation was there any local cause, such as inflamed follicles or sensitive papillæ.

With regard to treatment, my experience goes to show that a cutting operation is not necessary. Nor does it appear that this

adds much, if anything, to the curative effect of the subsequent dilation. In the fourth case Dr. Sims himself had performed this operation, and when I first examined the patient the greatest difficulty arose from the state of vaginismus, and I had to desist and resume it under chloroform. In the fifth case the same effect had been produced by a laceration of the perineum in the patient's only confinement. In these it was very evident that the vaginismus kept pace with the amount of uterine derangement.

In the discussion following the paper some differences of opinion were elicited.

Dr. Barnes said that vaginismus must be regarded like hysteria or neurosis, as simply a convenient term for a symptom which might be one or more of several causes. Dr. Bantock had associated vaginismus mainly with one condition, uterine inflammation; but he (Dr. Barnes) believed that Oldham was right in attributing some cases to morbid conditions of the vulva. Certainly some cases were, as Dr. Bantock described, associated with—he would say caused by—uterine inflammations. These inflammations and displacements were common, whereas true vaginismus was rare. Moreover, he had seen vaginismus without any tangible uterine complication. One of the most severe forms of vaginismus was dependent upon an irritable or inflamed hymen, or inflamed vulva with hymeneal remains. The remedy for this was circular removal of the hymen or its remains. He had assisted Tyler Smith many years ago in an operation of this kind, and had repeated it several times since with success. For some cases of more simple reflex contraction, forcible distention under chloroform, either with the fingers or better with his double crescent-speculum, had answered. Some cases he had cured by making a subcutaneous and submucous incision on either side of the vulva through some fibres of the muscle. For almost all cases he had found the Sims' vaginal rests most useful. He preferred this instrument to some he had contrived himself some years ago. The muscular spasm or contraction could not long hold out against continuous mechanical tension. It presently relaxed, and the disposition to spasmodic irritability subsided.

He regarded vaginismus as presenting analogies with the laryngismus and trachelismus of Marshall Hall, and it was one of the many illustrations of his theory of reflex or diastaltic action.

Dr. W. Culver James thought that some cases of so-called vaginismus were really due to obstruction caused by the presence of the hymen or growths.

Some years ago a patient applied to him under the following circumstances: She was in her fortieth year, and had been married eighteen years; her husband was an exceedingly healthy and strong man, but during the whole of that period he had been

unable to effect an entrance, 'owing to the presence of something which caused her extreme pain' on his approach. She had hitherto refused to be examined, and no doctor had been previously consulted. The catamenia had ceased for about a year.

A few days before the consultation her husband had attempted to have sexual intercourse, and had not only been unsuccessful, but had lacerated the mucous membrane of his urethra, and had in consequence suffered from urethritis and enlargement and inflammation of the testicle. This accident was the cause of her being persuaded to seek medical advice.

On examination one's finger was unable to be passed beyond the second joint, at which point it was firmly held by a ring of thick, rough, cartilaginous-like tissue, which completely surrounded the entrance to the vagina and prevented any further passage; it was very sensitive, and the presence of the finger gave rise to extreme pain. The posterior part of the thickened hymen was incised and a plug of cotton wool introduced.

The vagina, though considerably larger for the operation, was still small, and after a few days a 'Barnes' bag' was introduced, and worn every night for two or three weeks, at the end of which period the husband was, for the first time, able to have sexual intercourse.

In this case one incision followed by gentle and gradual dilation had been sufficient to afford relief, and there had been no need for excising the hymen.

In other cases he had found the remains of the hymen, even after parturition, give rise to severe pain when coitus was attempted.

Dr. Routh said that the plan recommended by Dr. Bantock, that very marked and severe cases of vaginismus could be cured by simple dilation was new to him. Even in the few cases cited by Dr. Bancroft, one was not a complete cure. He also could not accept the doctrine that all these cases were due to a reflex action in consequence of disease of the uterus. He (Dr. Routh) had invariably followed Dr. Marion Sims, and in several cases had succeeded. In one only had there been a partial delay in the cure. His method was to cut away all remains of the hymen, and then to make two deep divisions on each side of the vagina; he made the women wear from the very first day of the operation a full-sized Sims' glass plug, and from two to six hours daily, so that in fact the cut edges, as it were, healed upon the glass. In the only case in which he failed at first, in addition to the vaginismus, on the left side the levator ani was spasmodically contracted within the vagina, in two knots of fibres about as thick as the little finger. This case before he saw it had been operated upon in the normal way by another practitioner, and he had failed. Dr. Routh had

therefore in addition to making the two deep lateral cuts before referred to, through the sphincter vagina on each side, also cut subcutaneously the fibres of the levator ani.

This he had done twice, and now he believed connection was comparatively easy. He did not know, as Dr. Barnes had now recommended, that this subcutaneous section had ever been practiced before. He had been led to do so by his experience in a well-marked case of spasmodic stricture of the rectum in an old lady of over seventy, who every now and then became quite incapable of defæcation, with great local pain. On passing the finger he detected a hard circular ring in the fibres of the rectum, about two inches up. The subcutaneous section of these fibres cured her radically. He did not know how far a suggestion might not be made from cases of collygodinia in which connection was also impossible. That disease often was curable by cutting the nerves subcutaneously all round the last bone of the coccyx, and perhaps a similar proceeding might cure vaginismus by arresting reflex action to the vulval orifice.

Dr. Bedford Fenwick remarked that the paper they had just heard appeared to him to be not only very interesting but remarkably suggestive also—suggestive both pathologically and clinically, alike as to causation and treatment. For, as he understood Dr. Bantock, the subject under discussion was a rare symptom of a rare class of cases. He was sure the cases were very rare, although one of the speakers had been so fortunate as to see it appeared 'a great many.' He could only recall to mind two or three among the thousands of gynæcological cases which he saw every year at the hospital for women. Of course he did not refer to cases merely of irritable vaginæ from all sorts of definite and decided local causes. By the term vaginismus he understood simply more or less clonic contractions of the vaginal muscular wall; evidenced to the patient by pain and discomfort, intensified by touch, and to the examining finger by powerful spasmodic action. It seemed to him, then, that Dr. Bantock's paper was so suggestive pathologically and etiologically because he referred this spasm of the muscle to reflex action. There was not the slightest doubt he was theoretically justified in so doing. Look at the vomiting which occurred in pregnancy, in Addison's disease, in cerebral mischief; was not that simply and solely a spasm of the stomach muscle, due in each case to reflex actions from central or peripheral nervous irritation? Look at the spasm of the laryngeal muscles which occurred from pressure on the recurrent laryngeal by an aortic aneurism. There was no need to multiply examples. There could not be the slightest doubt pathologically that vaginismus *might* occur. But did it do so? He thought, therefore, secondly, that the paper was suggestive clinically, because it showed that,

though rare, such spasms of the vaginal muscle were met with. He, himself could remember one case well. It was in a patient at the Hospital for Women, a young woman who had, for some length of time, suffered intensely from dyspareunia, had been to many hospitals, had evidently suffered much of many physicians, but was rather worse. She had worn instruments. The hymen had evidently been sheared off, as recommended by Dr. Routh, and finally some energetic dilator had evidently ruptured the perinæum. The introduction of the finger into the vagina caused intense pain and such powerful muscular contraction that it was firmly grasped and even withdrawn with some difficulty. Dr. Fenwick noticed that there was a mass of large inflamed hæmorrhoids surrounding the anus, and sent her to his surgical colleague for treatment. She returned to him in a few weeks perfectly cured of the piles, and jubilant that the dyspareunia was cured too. And now, on examining the vagina there was not the slightest vaginismus. The muscular spasm had been evidently kept up by reflex nervous irritation, and completely cured by its removal. This was the only case, the full details of which Dr. Fenwick could recall at this moment, but his impression was that he had seen two or three not dissimilar cases. He thought, therefore, that Dr. Bantock's paper, as he said at first, proved that vaginismus, which was doubtless pathologically possible, was clinically reflex in its origin, and by the removal of its exciting cause perfectly curable.

Dr. Rutherford said he wished to confirm the remarks made by the last speaker (Dr. Bedford Fenwick) as to the reflex origin of vaginismus. A case that came under his notice at the Chelsea Hospital for Women, was a patient about thirty-two years of age, who first consulted him about a year ago for varicose veins. As she was expecting to be confined in a very short time, and the veins were not at all bad, he advised her to rest as much as possible. He did not see her again until some time in March last, when she said she had been delivered of her fifth child about the beginning of December, 1885. She now complained of feeling weak, with a heavy dragging pain in the pelvis, and pain in the small of the back.

Having examined her, and finding the uterus subinvolved, he ordered her a mixture containing iron and strychnia. She improved rapidly under treatment, and finally discharged herself as well.

Some time in June she returned again complaining of feeling debility, but chiefly on account of pain when her husband attempted sexual intercourse. He was not able to effect an entrance owing to the pain and spasm.

He examined her and found he was unable to introduce his in-

dex finger beyond the ostium vaginæ, owing to the spasm which took place. The rectum was examined for anal fissure, and the pendentum for fissures or ulcerations, but without discovering any. In order to pass the ostium vaginæ he painted the parts with a twenty per cent. solution of cocaine, and after waiting a short while got his finger into the vagina. The uterus and vagina were perfectly normal, but before dismissing her he stretched the vaginal orifice somewhat with his fingers. She was ordered iodoform pessaries every night. In a fortnight she returned and informed him that at first she could insert the pessary of a night, but latterly was unable to do so owing to the spasm. She now casually informed him that she had thread-worms; he told her to leave off using the iodoform pessaries, and ordered her an astringent enema, together with an astringent mixture.

When she next saw him, she informed him that there were no more thread-worms to be found in the stools, and that her husband could affect an entrance without causing her pain, and naturally. About the beginning of October she again returned with a history of thread-worms and vaginismus, neither of which were so bad as formerly. She was treated again for the tape-worms only, and soon returned saying she was better, since which he had not see her.

It seemed to him interesting to note on the two occasions of her discovery of thread-worms, how by treating the worms the vaginismus was cured.

As to the treatment by cutting or dilating, his experience would be in favor of dilation, as in two cases where the cutting operation was performed by a doctor for this complaint, in both the vaginismus returned, whereas in three cases in the practice of others, in which dilation was employed, not one of them had failed.

In those cases of simple vaginismus which are said to be mere neurosis, and in which nothing has been discovered as the cause, he would suggest a more thorough and extended search, as in his opinion a cause could always be found for the condition.

Finally, we should regard vaginismus as a symptom only, not as a disease.

Dr. Edis thought the discussion had wandered somewhat from the original subject of the paper—*viz*: vaginismus—to the more comprehensive one of dyspareunia. This latter term included all manner of different affections of the vulva, vagina, uterus, and appendages, and was hardly contemplated in the paper of Dr. Bantock.

Vaginismus, as defined by Sims, consisted in an excess of hyperæsthesia of the hymen and vulval outlet, associated with such involuntary spasmodic contraction of the sphincter vaginæ as to prevent coition. By many it was regarded as a pure neurosis,

no manifest assignable cause other than the intense hyperæsthesia. Even after the birth of a child the condition persisted in some instances.

It was curious to notice that the increase of experience of female disorders closely corresponded with a diminished frequency of cases of vaginismus. This was due, doubtless, to our being able to differentiate more precisely the conditions upon which the spasmodic contraction depended. Where no distinct cause could be detected, forcible dilation of the vagina, the patient being under the influence of an anæsthetic, seemed to be the most successful way of overcoming the difficulty. If careful search, however, was made, it would generally be found that some fissure—vascularity of the urethra or vulval orifice—or some other well-marked cause existed, the removal of which removed the symptom which had occasioned so much distress.

Dr. Blake observed that vaginismus as a primary idiopathic disease might exist, but he had never encountered a case.

The two most typical examples he had recently seen were associated with retroflexion and endometritis villosa. On the removal of those conditions the vaginal spasm promptly and completely disappeared. Vaginismus is said to occur as a result of plumbism. It is a reflex that might exist in the course of any pelvic disease; more especially, like the dysuria of men, under similar circumstances, it was prone to occur with diseases of the anus and of the rectum.

The president said he trusted Dr. Bantock would forgive him the very great heresy he was about to commit, but he could not listen to his paper without expressing deep regret that Dr. Marion Sims had ever coined such a barbarous term as vaginismus, to explain a condition which he (Mr. Tait) did not for a moment believe existed. Dr. Barnes had, with characteristic care and caution, pointed out that at the most the condition was to be regarded as a symptom and not as a disease, and that it is not in any way to be confounded with the cases where the difficulty arose from trouble in the upper part of the vagina and not at the orifice. His (the president's) difficulty was that some time after Dr. Marion Sims' original papers appeared, he (Mr. Tait) undertook a series of dissections in order to see this wonderful muscle to which such great powers were attributed, and out of eleven dissections he only found in one case traces of a few pale, irregularly-formed bundles of fibres to represent what in the text-books of anatomy was represented as a powerful structure. In anything like strong spasmodic contraction of this muscle he did not believe; in fact, he scouted the theory of vaginismus completely. To say that the few pale fibres which represent a sphincter-vaginal

muscle, such as he saw, could resist the entrance of the male organ was an absurdity.

As a matter of fact these cases in which difficulty of entrance was made on the part of the woman depended on two conditions—fear in many, and disease of the vestibule in the rest. The muscles which were called into contraction to resist entrance were the abductor dextrum muscles of the thighs and the glutei. For cases of fear a little reassuring and a slight opiate usually removed the objection. For diseases of the vestibule, appropriate treatment was necessary. The most common disease was the serpiginous vascular degeneration of the mucous membrane, which he (the president) had first described in 1876 (*Diseases of Women*, p. 43), a peculiarly distressing and obstinate disease, ending in atrophic contraction of the vestibule. Surgeons unfamiliar with this disease might easily overlook it.

—RETENTION OF THE FŒTAL MEMBRANES.—Dr. Fischer in the *Vratch*, states that he has met retention of more or less considerable portions of the chorion in forty-two out of 682 (or in 6.2 per cent.) cases of labor. Discussing the etiology of retention, he mentions that (a) the phenomenon occurs oftener when the third period of labor is managed after Ahlfeld's method than when Credé's method is employed (7.4 per cent. against 5.7 per cent.); (b) in primiparæ the retention is observed twice as frequently as in pluriparæ (9.1 per cent. against 4.9 per cent.); (c) an important causal part belongs to chronic inflammatory processes developing in the fœtal membranes, such as endometritis decidualis and choritis chronica. [The author's opinion is well supported, by, first, the fact that in twenty-nine out of forty-two cases of the retention, waters either passed too soon (ten cases), or were so slow to pass that it proved necessary to make a puncture (nineteen cases); meanwhile the latter means was required only in 28 per cent. of the remaining cases where no retention occurred; second, by the fact that the retention occurs more often in premature labors (8.2 per cent.) than in labors at full term (5.7 per cent.)]

Passing to treatment, Dr. Fischer observes that in all his forty-two cases of the retention he did not use any other prophylactic means except the administration of ten-grain daily doses of ergot. As a rule, the retained membranes come out spontaneously within four or six days after labor. In four cases (10 per cent.) hæmorrhage occurred, which, however, depended not upon the retention, but upon the pre-existing atonia of the womb, or decidual endometritis. In twenty of forty-two cases (47.6 per cent.) no fever was present, in twelve (28.6 per cent.) an isolated rise of temperature was observed, and only in ten (24.8 per cent.) cases repeated febrile rises occurred. The respective figures for the normal (non-

retention) cases which came under the author's observation during the same period were 58, 17.6, and 24.4 per cent. In thirty-two of forty-two retention cases, slight endometritis was observed; it disappeared under the use of ergot, quinine, and vaginal injections.

Basing his views on the facts as sketched above, Dr. Fischer comes to the general proposition that retention of the foetal membranes is pretty harmless and cannot give any indication for any therapeutic interference.—*Arch. of Gynecology*.

—A CASE OF LABOR OBSTRUCTED BY A TUMOR.—By J. NICHOLAS MITCHELL, M. D.—In May of this year I was requested by a friend, a man of large experience in obstetrics, to see with him a lady who had been in labor for some hours and who seemed, as he said, "to have neither cervix nor os." When I reached the house I found that the patient had been in labor some eight or nine hours; that the first symptoms of labor had been the discharge of a dark fluid in sufficient quantity to make her nurse announce it as the "the waters;" that the pains were coming with great regularity and were excessively severe, and that a discharge of a dark inoffensive character still continued. Upon vaginal examination, the vagina seemed to be a closed *cul-de-sac*, much shorter than usual; the roof and portion usually occupied by the uterus felt hard and resisting, and were not affected by the pains of the woman, and there was no posterior *cul-de-sac*, this space being filled in by this same hard, resisting body. Abdominal examination revealed two tumors in the abdomen, each one running obliquely upward in opposite directions from the pelvis, and thus leaving a certain amount of space between them at their upper extremity.

The tumor running upwards in the left side of the abdomen was found to grow hard under the hand when the pains came on, while that on the right was unaffected by them. A second vaginal examination succeeded in passing two fingers between the symphysis pubis and the hard presenting tumor, and with the tips of the fingers the os was felt above the brim of the pelvis, partially dilated and to the right side. Judging then that the tumor in the left side of the abdomen was the uterus with its cervix presenting thus at the right inguinal ring, the axis of the uterus was in such a position that if a straight rod had been passed through the abdominal wall to the right of the mons veneris it would have entered the cervix at that place and have passed obliquely upwards across the abdomen to the other side. It was also discovered that the breech presented, and a diagnosis made of labor obstructed by a tumor, probably ovarian. My first attempt was to push up the tumor out of the pelvis and push the uterus and child

down in its place. After long continued effort in this direction without success, I determined that one of two things must be done, *viz.* : either tap the tumor or perform a laparo-elytro-tomy. Before attempting either of these operations, however, we sent for further counsel. There was an interval of time from 9:30 A.M. until 1:30 P.M. before we again met with our added counsel. An examination revealed that during this time some change had occurred which permitted the hand to be passed by continued pressure between the symphysis and the tumor; our counsel advised against either tapping or cutting, and, himself, pulled down the breech of the child, and, being tired with his efforts, left me to deliver the head and shoulders, which was done without any great effort. The woman rallied very well from the operation and ether, but had no contractions following the delivery of the child. The placenta seemed to be entirely adherent since there was no hæmorrhage. During this time of waiting for the placenta, I again made an effort to push up the tumor out of the pelvis, but was still unable to do so. After waiting for awhile, without contractions ensuing, friction over the abdomen and medicines were resorted to, and a severe hæmorrhage coming on, the hand was passed into the uterus and the placenta, which was found partially adherent, was removed. The woman rallied well from the labor, and after putting a few stitches into the torn perineum, which needed no ether to perform, I left her some three hours after the delivery, with a fairly good pulse, a temperature of 100.5° , with a perfect consciousness and recovery from shock, and with a fairly contracted uterus. This was at 9 P.M.; at 6 A.M. the following day I was called to her, and found her colorless, pulseless, and restless, throwing her hands up over her head, and gasping for breath, partially conscious, and with cold and clammy extremities. The hand placed on the abdomen could discover the tumor in the right side of the abdomen but no uterus could be felt. I then discovered that no discharge of blood had occurred externally since I had left. The woman very shortly died. Unfortunately no post-mortem examination was allowed, but from the fact that I could feel no tumor, suggesting a concealed internal hæmorrhage, and that there had been no pains, and no discharge externally, and knowing that she had rallied from the shock of delivery before I had left her on the evening previous, I concluded that there must have been a rupture of the uterus, and that the constant flow of blood through this rupture had produced her death.

I thought she had rallied too completely from the shock for that to be looked upon as the cause of death, and felt that if the tumor had ruptured we should have had symptoms from the beginning and no rallying from the shock. Whereas, I supposed that possibly the laceration at first might not have extended through the

peritoneum, or might have been closed by the first contraction. As an interesting fact it may be stated, that I learned some weeks afterwards that she was the third in her family who had died from ovarian tumors complicating labor.

Remarks.—All authors agree that a tumor complicating labor and obstructing the pelvis is of the most serious import to both mother and child. Anyone who has had to contend with such a case has the subject brought to his attention in such a way as to impress this fact upon him more than any words or writing can possibly do. This makes the third case in my experience. In both the others it was possible to push the tumors up out of the way. One case then needing version by the feet to effect delivery ; the other after the tumor was pushed up, was delivered naturally. In both cases mothers and children were saved.

Hodge notes as quoted from Cayeaux Puchell's statistics as follows : Out of thirty-one cases, fifteen women and twenty-three children perished. One woman and twenty-one children died during labor. In five cases where no assistance was offered, four women and three children died. In one case, the child and mother were saved by pushing up the tumor ; in a second case the child died but the mother survived. Version was performed twice—after pushing up the tumor—both children and one mother perished. Puncture of the tumor was made in three cases ; one woman escaped, two women and three children died. Incision of the mass was performed in four cases ; three of the mothers and one child survived ; one mother and three children were lost. In one case, where the forceps was applied, the mother and child perished. Craniotomy was performed six times, three of the mothers only recovering. The blunt hook was used in some cases, with safety to both parties. Dr. Merriman reports eighteen cases : Of these, nine mothers died, three recovered imperfectly and six completely. Dr. Litzmann reports fifty-six cases : twenty-four mothers died and thirty-two recovered ; of the children seven were born alive, thirty-five were still-born and of the remainder no account was given.

Playfair tabulates fifty-seven cases. In thirteen, labor was terminated by the natural powers alone, but of these, six mothers, or nearly half, died. In favorable contrast with these we have the cases in which the size of the tumor was diminished by puncture. These are nine in number, in all of which the mothers recovered, five out of the six children being saved. The reason of the great mortality in the former cases is apparently the bruising to which the tumor, even when small enough to allow the child to be squeezed past it, is necessarily subjected. This is extremely apt to set up a fatal form of diffuse inflammation, the risk of which was long ago pointed out by Ashwell, who draws a comparison

between cases in which such tumors have been subjected to contusion and cases of strangulated hernia ; and the cause of death in both is doubtless very similar. This danger is avoided when the tumor is punctured, so as to become flattened between the head and the pelvic walls. On this account I think it should be laid down as a rule that puncture should be performed in all cases of ovarian tumor engaged in front of the presenting part, even when it is of so small a size as not to preclude the possibility of delivery by the natural powers.

Barnes gives the following summary of Rules of Management of Labor Complicated with Tumors : " 1. Push the tumor above and aside if possible. 2. If the tumor be fluid and it be thought better not to attempt its removal, tap it by aspirator-trocar. 3. If solid, puncture by aspirator-trocar, and if still undiminished in bulk, remove it if possible. 4. If the tumor cannot be acted upon advantageously, reduce the bulk of the child. Turn, perforate, crush the head by cephalotribe, reduce by lamination. 5. If neither tumor nor child can be advantageously acted upon per vaginam, resort to the Cæsarian section."

As in our case nothing but an attempt to push up the tumor was made and none of the other rules laid down above—though puncture or laparo-elytrotomy, if that failed, was suggested by me, but overruled at the consultation. It may be proper to say that labor had been going on for so long a time before our consultant arrived that he thought that the risk of infection was greater than the likelihood of damage by compression, since so much more space presented for delivery by this time than was found earlier in the labor.

The delivery of the child was remarkably easy considering how small the space had seemed at first, but from the oblique position of the uterus above the pelvis and lying across the tumor, the pressure of bringing the child into the axis of the pelvis was brought to bear upon the posterior wall of the uterus, by having to pull at right angles to the axis of the uterus, and across the tumor like a lever below, and I fear that the strain was too great and resulted in a laceration of the posterior wall of the cervix and that this laceration extended into the body.

From my experience in this case I have determined that even when there seems, as there did in this case finally, to be room enough to give passage to the child, that if attempts to push up the tumor fail, either puncture should be tried, or in case of failure to empty the sack, operation for removal of the child either by craniotomy or through the abdominal walls by some one of the different operations, should be attempted. In this case, from the position of the uterus, Thomas's operation of laparo-elytrotomy suggested itself to me. Statistics of craniotomy in these cases

show very conclusively that the mortality is as great as in Porro's operation under ordinary circumstances, so that I should feel inclined to give the child the benefit of this latter operation, or, if practical, of Thomas's.

—A CONTRIBUTION TO THE DETERMINATION OF SEX.—Derived from observations made on an African tribe.—Dr. R. W. Felk in the *Ed. Med. Journal*.—In Uganda and the Egyptian Soudan, which the Rev. C. T. Wilson and I published in 1882, the following sentences will be found: "The female population (of Waganda) is largely in excess of male, the proportion being about three and a-half to one. This excessive preponderance of the females over the males is due to three causes:

"1. Careful observation has established the fact that there are a good many more female births than male, and on taking the groups of children playing by the roadside, there will always be found to be more girls than boys.

"2. The Waganda are constantly at war with one or other nations round them, and their battles, being hand to hand encounters, are fearfully destructive. In one engagement which came under my immediate notice, fifty per cent. of the Uganda warriors were killed, and, as they gained the day, the loss of their opponents must have been even greater.

"3. The rule with the Waganda, when they have taken a town or district, is to put all the full-grown men to death, and to take the children and women prisoners; and as the Waganda are almost always at war, there is a constant influx of women, who are distributed among the chiefs and successful warriors."

In doing my part of the work on which these statements are made, I jotted down some figures, which I summarize as follows: "The result of inquiries made into the history of 300 pure Waganda women was that 291 had children, and of the first births 144 were males, 147 were females. Of 500 imported women into whose history I inquired, 482 had children. Of the first births only 79 were males, and no less than 403 were females."

These figures were rather startling to me, and set me wondering how they might be explained. After a good deal of thought, I have come to the conclusion that there is only one possible explanation, and I propose, as briefly as possible, to set that explanation before you.

In order to avoid any misunderstanding I must state that the notes on which I base my theory were made partly in Rubaga, the capital of Uganda, in part on a journey I made from Rubaga towards the Nile to the east of that place, and lastly, on my march from the capital to the northern frontier of Uganda, on my way home in 1879. I also made some other observations,

which will serve as a control, in the Egyptian Soudan and on the east coast of Africa.

With the total population of Uganda, and with the excess of females over males, I have on the present occasion nothing to say, save to call your attention to the very marked difference found there when compared with the statistics of other countries, but this excess is, I think, fully explained in the quotation I made from *Uganda*.

In a paper by Sir R. W. Rawson, page 153, *Bulletin l'Institute Internationale de Statistique*, I find the following facts, *viz.*, that in England and Ireland there are 49 male to 51 females; in Scotland there are 48 males to 52 females; in the whole of Europe, including Russia, there are 97.4 males to 100 females; in the United States of America there are 51 males to 49 females; as compared with 100 males to 350 females in Uganda.

In only four European States do we find an excess of males over females, *viz.*, in Italy there are 105.5 males to 100 females; in Servia 103.6 males to 100 females; in Roumania 105.9 males to 100 females; and in Greece no less than 113.1 males to 100 females.

In looking over my notes made in Uganda, I asked myself the question, How is it that so many of the women imported into Uganda bear such an excess of female children in their first pregnancies? For I found that among the pure Waganda women the excess of first female births was comparatively small, *viz.*, 100 males to 102 females, as compared with 100 males to 510 females in first births from imported women; and that in subsequent pregnancies of these imported women a more equal ratio prevails, *viz.*, about 100 males to 137 females, although this is a far higher ratio of female birth than obtains in any European State.

The only theory which occurs to me, and which I confess seems to answer the question I have proposed, is that "the temporarily superior parent produces the opposite sex."

I must now proceed to explain how I think this theory fits in with my facts.

The Waganda are a very war-like race; they are nearly always at war with some of their neighbors; they are disliked and dreaded by all the surrounding tribes. It is their custom to kill all the grown-up males and very old women when they have conquered a village or district, and they lead away captive all the boys, young women and girls. The boys are subsequently sold to Arab slave dealers; the girls and women are taken as wives. Now, with the exception of the great chiefs who command the army, no soldier is permitted to take a wife along with him to war. The result is that, after the sack of a village, the utmost license prevails, and the nights are spent in excess of every kind.

Now, looking at the condition of the men and women thus suddenly brought together, we find that the men are flushed with victory, are exuberant, and after having lived for many days on dried bananas, they partake freely of cattle killed for the occasion and the native wine they have stolen aids in exhilarating them; but you must note that this native wine is not strong and the alcohol it contains is very pure. The women, on the other hand, are frightened and sorrowful at the loss of their freedom, homes and friends (for an African woman loves her home and friends as much other human beings do). They are compelled to perform exhausting dances for their captors' amusement and are then ravished, subsequently being compelled to take long marches to which they are unaccustomed.

The man, I hold, in this case is superior—mentally he is elated, physically he is in good condition. The woman is inferior—mentally cast down and physically exhausted. What follows? An enormous excess of female children. Therefore, in this case at least, the temporarily superior parent produces the opposite sex.

Unless I am much mistaken, my control observations tend to uphold this theory, for I found that of women captured by the slave-raiders in Central Africa, and brought down to the East Coast, either near Zanzibar or through the Soudan to the Red Sea, those who had been impregnated on the way usually produced female children.

In this case also the same factors are at work—the women compelled to long and exhausting marches, to bear heavy chains, yokes, and loads, water and provisions being scarce; the men well fed and without care. In talking with Soudan slave-dealers, I was told in answer to my inquiries that, as a rule, only women who had previously borne children are impregnated *en route*, as the young girls are generally “sewn up.” The slave-dealers said it did not matter about the older women, for they nearly always produce girls; so that instead of having only one slave to sell, they have a woman and a female child.

I must next look at the condition of the women imported into the Uganda after their arrival, and when they have been distributed to men as rewards for service in the field. Other factors now come into play, which may or may not uphold my theory. Dividing the Waganda men into three classes, there are first, the chiefs, who have large harems; secondly, men who have several wives (six to twenty); and lastly, those who have only one or two. This last class do all in their power to marry pure Waganda women. Why? Because the pure Waganda women elongate their *labia minora*, and the Waganda prefer such women, unless they can always have a fresh supply. They think that the result of the elongated labia is an increased desire on the part of the

woman, and hence an enhancement of their own pleasure. It is found as a consequence that in the families of the poor the sexes are as evenly balanced as in Europe.

Among the other classes the men do undoubtedly commit great excesses, but their wives, if they are imported women, have all the work to do, and are therefore *inferior*. Against this, however, must be noted the fact that from the time they become pregnant they live separate from their husbands until such time as they have weaned the children, which is about two years of age.

The ratio of female births after the first among these imported women is more nearly like that of the pure Waganda women, but it is still far higher than in Europe, *viz.*, about 100 males to 137 females. I can only throw out a hint as to a possible support of my theory in the examination of Europeans. I have not worked out this point fully, but I find that in the majority of cases in which a child is born in England under ten months after marriage in the higher classes after a "*honeymoon*" it is male; in the lower classes, and where there has been no "*honeymoon*," it is female. Why this should be the case is too obvious to specify.

Before concluding this paper I should like to call your attention to two other points of interest which are brought out by my observations: first, the small per centage of women who *appear* to be sterile in Uganda. In 300 pure Waganda women I observed only 9, or 3 per cent., had no children. In 500 imported women observed only 18, or 3.6 per cent., were childless, as against about 15 per cent. of women who, I believe, are sterile in England. The second point is the number of children born of these 800 women. Of the 291 pure Waganda women who had children, 74 had 1 child, 35 had 2 children, 140 had 3, 36 had 4, 2 had 5, 1 had 6, and 3 had 7. Of the 482 imported women who had children, 79 had 1 child, 260 had 2 children, 107 had 3, 37 had 4, 1 had 5, and 2 had 6.—*Arch. of Gynecology*.

—INSANITY OF GESTATION, OF DELIVERY, OF THE PUERPERAL STATE, AND OF LACTATION.—*Case I.—Insanity of Gestation.*—Mrs. S. A. McG., aged 42, mother of seven children. Family history, stepsister insane. Previous history, had fits when a child, during adult life has been subject to facial neuralgia. History of present disease, three months previous to confinement she had delusions of suspicion, imagining people and friends were trying to do her injury, and that her food was poisoned. At times she became excitable, this alternating with periods of depression, during which she stared vacantly and was indifferent to surroundings and circumstances. Confinement was natural. At the date of first visit, one week after confinement, she was very irritable, restless, always moving about, talking nonsense in an incoherent

way to herself. She slept well and took food well. Had delusions of a religious character, that she saw Jesus Christ and that her room was full of angels.

R.—Stramonium, 30.

One week later all the mental symptoms had disappeared, but there was a yellowish, thick leucorrhœa, with bearing down pains for which sepia 6x was given. Two weeks later she was discharged cured.

Case II.—Insanity of Delivery.—Mrs. A. R., age 27, two children. No family history of neuroses. The first symptoms appeared during labor. She became despondent about her future welfare and made an attempt to poison the child. Within a few days she had hallucinations of sight and hearing; she said she was a witch and adorned herself with all sorts of ribbons, rags, etc. At times she is violent and does not recognize her relatives or friends, and within a few hours she, again, is quite sensible. Complains of sharp, pressing pain in centre of the forehead, coming in shocks or jerks. Under the influence of Zincum phos. 6x, this case made good recovery in a month's time.

Case III.—Insanity of the Puerperal State.—Mrs. E. L., age 20, one child. Family history, her mother had two attacks of melancholia following parturition. Previous history, had a miscarriage thirteen months ago, following which she was rather queer. History of present attack, confinement one month ago, labor two and one-half hours, forceps used, no hemorrhage. Earliest symptoms appeared one week ago; first became excitable and incoherent. On examination, a woman of middle height, fair, rather thin and anæmic, talks rationally at times, at others is silly, talking nonsense, says she is the Queen of England and snubs her family and friends. Platina 200. One week later the symptoms changed entirely. She manifested continued fear of imaginary objects, loss of memory, dilated pupils and twitching of muscles of the face. Stramonium 3x restored her to health within a week.

Case IV.—Insanity Consequent Upon Prolonged Lactation.—Mrs. E. M., age 29, three children, duration of attack four months. No previous history of neuroses, but she has been subject to attacks of acute rheumatism of the loco-motor apparatus. Following one year of lactation, acute mania appeared. She first became excitable and restless. When examined could hardly be kept quiet long enough to answer questions. Declared she had seen the devil. Was obscene, noisy and burst into fits of laughter, followed by incoherent, loud talking. Hyocyamus 3x. Improvement followed the use of this remedy, but the loss of her child two months after produced a condition of melancholia which yielded to Ignatia 30, and four months from the onset she was discharged cured.

H. H. C.

—**ANTEFLEXION** with mobility, in a virgin, is a physiological condition, and can only be called flexion when the uterus becomes immobile and bound down by adhesions.—**PROF. PARVIN.**

—**CIRCUMCISION FOR THE CURE OF ENURESIS.** BY **SAMUEL S. ADAMS, M. D.,** Washington.—Several years ago I advocated the removal of the elongated prepus for the cure of incontinence of urine only under certain conditions in a small class of patients. Further observation has led me to broaden the scope of the operation. If after the eighteenth month the urine is passed involuntarily, instead of accepting the popular impression that frequently laziness is the prime etiological factor in enuresis, I have found that aspecific pathological state could be found which yielded promptly to treatment.

Many a boy has been repeatedly punished for wetting the bed in the face of protestations that he could not help it. The disease and punishment go on together until his family are compelled to seek professional advice. Then the parents learn that they have been chastising their child, for a fault which was the result of disease and, therefore, uncontrollable. Again there are others who, while they believe the act involuntary, will let it run on for years with the hope that education and the inculcation of habits of cleanliness will effect a cure, or with the belief that their only hope for relief is in the establishment of puberty.

In too many cases the act continues untreated, in spite of punishments. The boy loses his vivacity, becomes morose and spiteful, pale and haggard, restless and nervous; will not look you in the face; and with chin depressed and upper lids drooping, presents, indeed, a striking likeness of the onanist.

We generally find the disease divided into three varieties. In the first class the subject suffers from a constant dribbling of urine day and night. This variety is infrequent, and is usually associated with some serious pathological lesion, consequently does not fall within the scope of this paper. A second class comprises those whose enuresis is intermittent and occurs in the day as well as at night. In this class the urine is retained for a short time during the day, when the desire to void urine comes, but before the child reaches a convenient place the sphincter is overcome.

The third class is one that interests us most because of its frequency, its nocturnal character, its possible concealment for years, and the promptness with which it yields to treatment. Children of this class usually urinate before retiring, and yet about midnight, or, just before rising in the morning the contents of the bladder are involuntarily set free. Patients of this class generally dream of urinating, and it takes place during erection of the penis. Again, we meet with cases where the cause is obscure. In these

patients I attribute the accident to causes that favor a perfectly physiological process in the adult. We know that late suppers, rich food, wines, certain positions during repose, profound sleep, amorous or lascivious dreams, produce a nocturnal pollution in the adult, and I am convinced that these same causes excite a similar irritation in the child; but instead of the seminal discharge, the physiological process of which is not yet estab-

lished, the bladder is emptied.

In each instance the discharge is the result of a conservative process of nature to relieve the irritation. This theory seems plausible because in many instances the nocturnal bed-wetting goes on undisturbed until the full establishment of the sexual functions, when the enuresis is superseded by nocturnal pollutions.

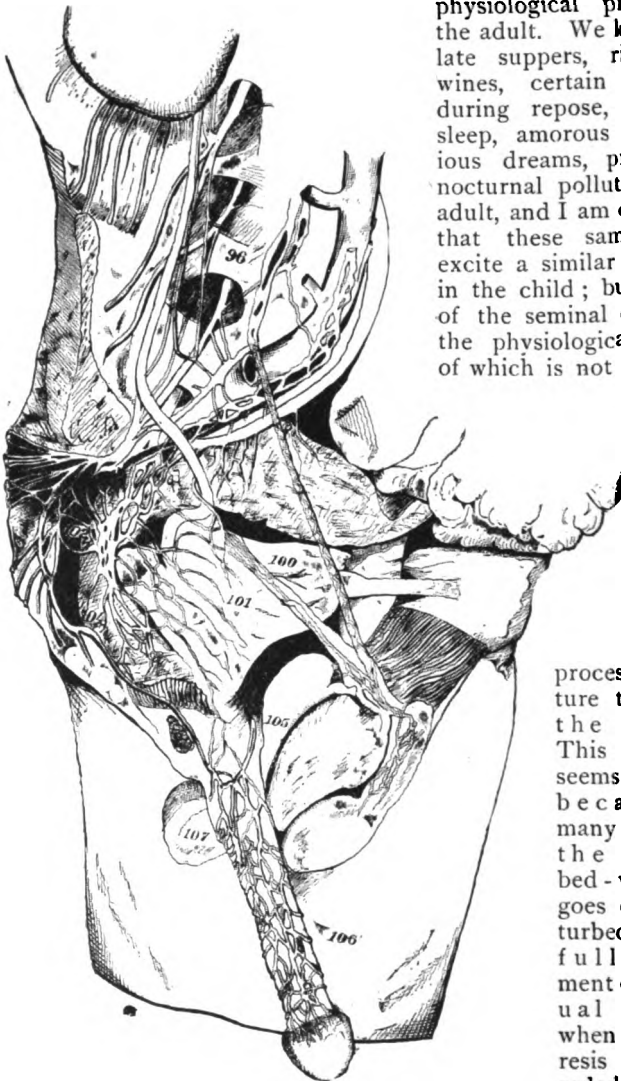


FIG. 1.

Formerly I did not advocate circumcision in all cases of elon-

gated prepuce because I believed that if the adhesions were broken up, thus rendering the prepuce capable of retraction, the enuresis would be cured. Further clinical experience has demonstrated that there are a number of cases that will not be cured as long as the redundant prepuce remains, where the prepuce is adherent to the glands, the destruction of the adhesions will afford only temporary relief. In some cases after an assiduous trial of the numerous measures, with the exception of circumcision, treatment is abandoned with the hope that the physiological changes of puberty will correct the malady. In such cases early circumcision would have accomplished the desired result.

In cases in which the enuresis is attributed to phimosis, there should be no question about the surgical procedure. It is, however, in those where the prepuce can be easily retracted, or where it is free after the rupture of the adhesions, that there seems to be any question about the advisability of the operation. In children under eight years there does not seem to be any hesitancy about operating, but after this age there is a tendency in the profession to delay operative measures until the child's health is impaired.

The clinical picture of these cases is a familiar one. The previous history of good general health will exclude any organic disease as the etiological factor. The child, now approaching puberty, has been the subject of enuresis from early childhood. It may be diurnal, nocturnal, or hyperæsthetic, the treatment has been prolonged and rigid. At first the diet was restricted; then liquids were withheld late in the evening, the child sent to bed with burning thirst; he has been awakened at night to void urine; masturbation has been suspected but not proved; nauseating vermifuges have been administered; laziness has been suggested and the lash applied; the penis has been constricted with a string and balanitis has been the result; the patient has passed the gauntlet of polypharmacy; and, finally, some devotee of adherent prepuce hopes for a cure by breaking up the adhesions and removing the smegma from behind the glans penis. He is now brought to you with impaired strength. On examination you find the prepuce projecting from one-fourth to one half inch beyond the meatus; the opening is small and its margin is irritated; and on retracting it you find an ichorous foul-smelling collection behind the corona. The glands irritated and inflamed.

It may be asked how this condition will act as an exciting cause of either of the forms of enuresis. To answer this question it will be necessary to study the nerve-supply of the penis and bladder, which is derived from the pudic nerve, giving branches to the musculi-bulbo and ischio-cavernosa and then passing to the glands, where it breaks up into sensory filaments. A portion of these final branches possess a special kind of end-bulb, called genital

corpuscles. It also receives branches from the hypogastric plexus. The upper part of the bladder receives its nerve-supply from the hypogastric plexus of the sympathetic, and the base and neck are supplied by branches from the fourth sacral nerve.

The connection between the sympathetic and spinal nerves is well shown in the cut (Fig. 1), taken from Rüdinger's Anatomy and an ink-drawing by Dr. Wm. T. Gill, of the Children's Hospital, District of Columbia.

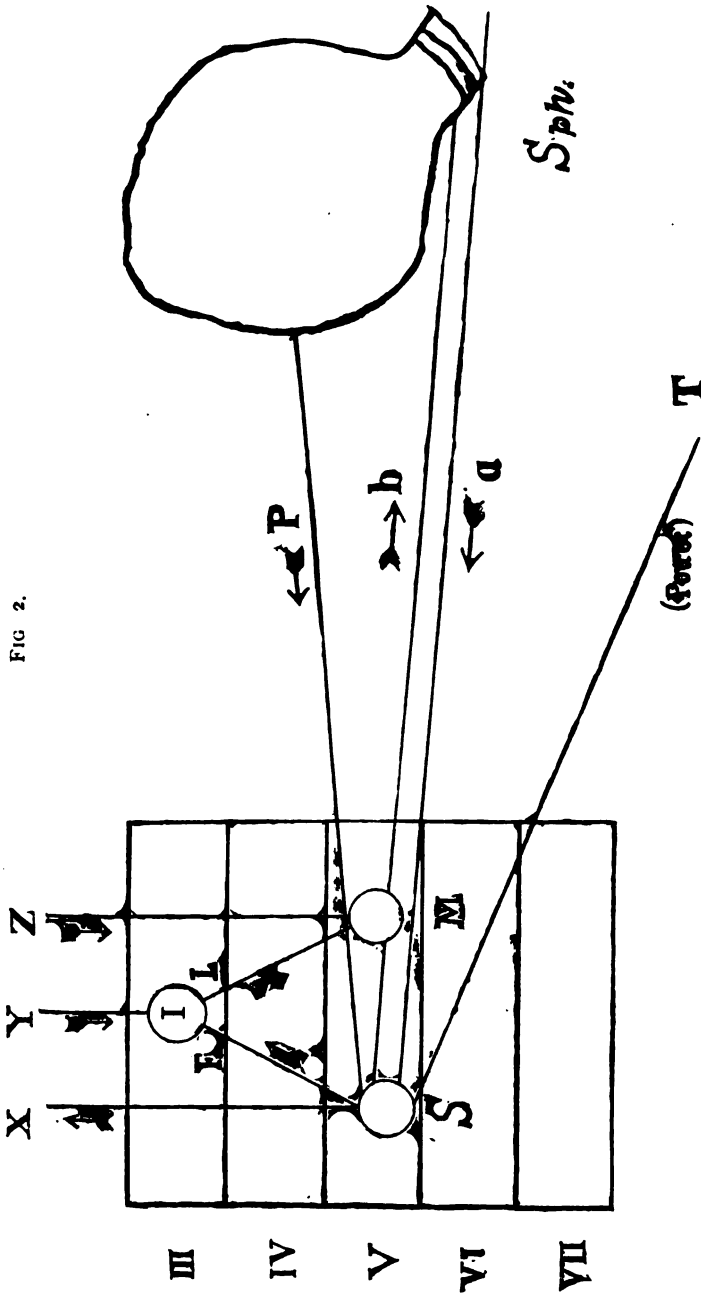
The communicating branches (96) between the lumbar nerves and the lumbar portion of the sympathetic, the inferior hypogastric plexus (97), which is a direct continuation of the superior hypogastric plexus, and the vesical plexus, (101), which is derived from the inferior hypogastric plexus, demonstrate the intimate relation of the sympathetic nerve-supply of the bladder with the lumbar nerves. The dorsal nerve of the penis (105) joins that of the opposite side and communicates with the sympathetic (of the cavernous plexus) on the back of the penis by fine branches (106). The strong, thick, winding branches (107) are the endings of the spinal dorsal nerve of the penis, which joins the sympathetic branches by numerous communications.

Hence it will appear that if there be such an intimate relation between the spinal and sympathetic nerve-filaments of the penis and bladder, then an irritation of the former should affect the latter according to the laws of irradiation and reflex action.

When there is only a small quantity of urine in the bladder the elasticity of the urethra, prostate, and sphincter prevents its escape. If the bladder is greatly distended its sensory nerves are stimulated, and the sphincter is dilated so that a few drops of urine escape into the urethra. There is not only the subjective feeling of a full bladder but also a reflex contraction of its walls; but at the same time there is a contraction of the sphincter and urethra which prevents the passage of these drops of urine. As long as the pressure within the bladder is not very high the reflex activity of the sphincter overcomes that of the bladder, as in sleep; but with rise of pressure and increased distention the muscular contraction of the bladder overpowers the controlling action of the sphincter, and the urine is voided as occurs normally in young children.

The nerves exerting the controlling influence are: 1. The motor nerves of the sphincter urethræ, derived from the anterior roots of the third and fourth sacral nerves. 2. The sensory nerves of the urethra, from the posterior roots of the third, fourth and fifth sacral nerves. 3. Fibres passing from the brain to the motor fibres of the sphincter urethræ. 4. Inhibitory fibres exerting a modifying influence over the reflexes of the sphincter urethræ, pass downward through the cord to where the third, fourth, and fifth sacral nerves leave it. 5. Sensory nerves pass from the

FIG 2.



NERVOUS MECHANISM OF THE BLADDER (Power).--a, afferent nerve of sphincters; **S** and **M**, sensory and motor centres; **X**, sensory fibres to brain; **Z**, motor fibres from brain; **V**, inhibitory fibres; **I**, inhibitory centre.

urethra and bladder to the brain, but their course is not known. Some of the sensory and motor fibres lie in the sympathetic.

The centre for the reflex stimulation of the walls of the bladder is situated, in the spinal cord of the dog, opposite the fourth lumbar vertebra, and is higher than that for the sphincter. Physiological experiments have shown that irritation of the lumbar portion of the cord will cause contraction of the bladder, and that division will produce paralysis. Also that irritation of either the sympathetic or spinal nerve-filaments going to the hypogastric plexus will produce contraction of the bladder, more powerful in the latter than in the former. The most energetic stimulus to the muscular contraction of the bladder comes from the spinal cord through the sacral nerves.

Power writes: "Looking at the ordinary sensations that are experienced as the bladder fills, we may conclude that sensory impressions, rising gradually in intensity, are conveyed (through P) to the sensory ganglia (S), from whence they are reflected (through *b*) to the motor centre (M), and from thence to the sphincter, causing this to contract more firmly. If the bladder becomes greatly distended the impression is no longer wholly reflected, but passes onward and upward to the brain (through S and along X), and excites conscious uneasiness or pain. If it be desired to retain the water, an impulse is transmitted by motor fibres (through Z) to the motor ganglion, M, and the *excito-motor influence (of S) on the sphincter is intensified by the will.*

"But suppose that instead of holding the water it be desired to discharge it, what happens? The phenomena that are then presented seem to necessitate the admission of an inhibitory, restraining or, regulating centre, which must be in close proximity with the excito-motor centre, and, therefore, at the lower part of the spinal cord, for the action of the will in this matter is not, like its own voluntary muscles, rapid and instantaneous, but is exerted only after the lapse of a distinct interval, and the result is a relaxation of the sphincter.

"We may conceive this impulse to pass down special fibres, Y, to an inhibitory centre I, which may either act directly (through L) on the motor-centre, M, or possibly may send branches directly to the sphincter muscles."

Landois showed that contraction of the bladder is not excited directly by a voluntary impulse but by reflex action. If we try to urinate when there is only a small quantity of urine in the bladder, we first stimulate the sensory nerves in vesical end of the urethra, either by causing contractions of the sphincter or by means of slight abdominal pressure, and thus force a little urine through the urethral orifice. Its presence causes a sensory excitation and a reflex contraction of the vesical walls. At the same time this

condition is maintained voluntarily by the action of the intra-cranial reflex inhibitory centre of the sphincter.

It seems probable that these mechanisms within the body, the inhibitory centres, exercise control over the reflexes. Thus in the adult the inhibition of the reflexes may be voluntary, as keeping the eyes open when the eyeball is touched. But this suppression is only possible to a certain extent, for if the bladder is greatly distended the stimulus to void urine is strong and frequently repeated so that the reflex impulse overcomes the voluntary effort. So in the child the urine is retained for a time, but when the reflex impulse is of sufficient force to overcome the resistance, whether voluntary or involuntary inhibition, it escapes from the bladder.

Thus it seems reasonable that any irritation of the terminal filaments of the pudic and hypogastric distributed on and around the glands being of sufficient intensity to overcome their ganglionic termini will also expend its force on the center of urination, and the bladder will also respond to the stimulus.

In the adult the utmost vigilance is required to prevent troublesome inflammation of the glands. When the prepuce covers the organ it becomes very sensitive. The natural secretions of the glands soon become offensive and irritating unless extra precaution are taken to secure cleanliness. In some the secretions becomes acrid if left pent up for twenty-four hours. The accumulation soon sets up a vesicular inflammation of the corona and adjacent mucous membrane, which is characterized by intense itching, burning, foul odor, painful erections, and frequent micturition. This condition is rarely seen in those who have the glands penis uncovered. If such a condition so frequently occur in those who take precautionary measures to prevent it, what must be expected of the child that even by the strictest supervision will not regard the hygiene of person? Upon retracting the boy's prepuce you see an offensive accumulation covering an irritated or inflamed area.

My belief is that this peripheral stimulus not only affects the ganglion of the pudic, but being of sufficient intensity it also excites the centre and nerves of urination. If it were otherwise how can we account for the speedy cure of enuresis by circumcision?

The object of this paper is not to deal with clinical histories, in only one instance have I known the enuresis to continue after circumcision. The boy, eleven years old, retained his urine all right for several days, when the enuresis returned, but not as bad as before. As I had treated him for gonorrhœa—as well as a sister of nine years, whom he had infected—six months before operating, and knowing him to be incorrigible and untidy, I rather incline to the opinion of his parents that he now wets his

bed from force of habit and laziness. It may be due to stricture, but if he hears that I am in his neighborhood he runs away, so it has been impossible to exclude this cause.

The prejudice which formerly existed among the laity against circumcision seems to be rapidly passing away, and now when we can offer a reasonable hope that the operation will cure the disease there is an eagerness on the part of the parent, and, many times, the child, to have it done.

One objection to the operation is that the glands will be left uncovered, and that it destroys to some extent the sensitiveness of the organ. If this were true it would in many cases prove a great blessing, but, unfortunately, it is not true. Another objection is that the beauty of the organ is destroyed, whereas, in fact if the circumcision is neatly done, the penis presents a far better appearance than it does with a redundant foreskin. I am in favor of operating early if the prepuce covers the glands, whether retractable or not and not regarding the operation as a *dernier ressort*. *Arch. of Pediatrics*, J. B. LIPPENCOTT Co., Phila.

—ANÆSTHETICS DURING PARTURITION.—In the Boston *Medical and Surgical Journal*, Feb. 10, 1887, Dr. Fordyce Barker says that "During the past thirty-seven years I have rarely attended a woman in confinement without the use of chloroform, never where she has suffered considerable pain. Having thus used it in several thousand cases I unhesitatingly assert that in not a single case have I ever found cause to regret its use." W.

—GRANULAR DEGENERATION OF THE CERVIX UTERI.—Dr. Gray, Edinburgh, says: "A short time ago I procured from the Rio Chemical Co., some Ext. Pinus Canadensis. I had a patient under treatment for granular degeneration of the cervix uteri, she was a multipara, aged thirty, had given birth to her first child eight years ago, an interval of seven years without any pregnancy elapsed, owing to leucorrhœa and chronic endometritis, which were cured by the ordinary treatment, occupying however, nearly twelve months. After this pregnancy of her second child occurred; but again, within six weeks after the birth of this child, in November, 1885, the granular degeneration manifested itself, and cervical catarrh, for which I put her upon the usual treatment, but slow progress was made. I directed my patient to mix a tablespoonful of Ext. Pinus, with water and use as a douche for two days. On my next visit, I twisted a bit of cotton wool around a Playfair probe, dipped it in the pure Ext. Pinus, and, after cleansing the mucus from the cervix, applied the probe, charged with the extract to the canal; I then made a tampon and saturated it with the extract and applied it direct to the cervix; in two

days removed and applied a fresh tampon saturated as before ; then again passed Playfair's probe, armed as before ; afterwards directed my patient to use the extract with the douche. Within fourteen days from the first application every trace of cervical catarrh and erosion had disappeared. [Pinus C. or Hemlock Spruce has for quite a number of years been employed internally for that form of reflex dyspepsia or 'false dyspepsia.' So often associated with uterine disorders. Dr. T. F. Allen in his encyclopedia gives an excellent report of this much neglected drug. P."]

—ABDOMINAL SURGERY.—The relative merits between the antiseptic and non-antiseptic treatment in abdominal surgery has been carefully compiled by Dr. Manton in the following remarks in a Paper on Ovariectomy : "It is necessary that we should have either a standard of comparison by which to gauge our observations, or a test of the method against some other under exactly the same circumstances. Obviously, the first of these propositions is impossible, and the second, very difficult of attaining as regards antiseptics and non-antiseptics in abdominal surgery.

But we have, in the results of two of the surgeons at the Samaritan Hospital, as correct a solution of this vexed question as can ever be arrived at. In Dr's. Bantock and Thornton we have two operators of as nearly equal skill, as it would be possible to find. The wards under their charge are equally well arranged and cared for, and the conditions under which they operate quite the same. After months of careful observation, I am certain that neither of them get all the difficult or all the easy cases, but that these are equally divided between them. Thornton, employs the strictest Listerianism, including the spray, at his operations, while Bantock has discarded antiseptics *in toto*.

What are the results ?

In Dr. Bantock's 162 cases just referred to, the operations are described as "non-Listerian, Listerian, and modified Listerian, and the combined mortality from these various methods is 14.8 per hundred.

During the twelve months ending December, 1885, there were done at the Samaritan Hospital 111 abdominal sections of all sorts, with eight deaths, a mortality of about 7.2 per hundred.

Of this entire number Bantock did forty-three operations, with four deaths, a mortality of just over nine per hundred.

Of Thornton's 150 published cases, there was a mortality of ten per hundred. In 1885 he performed fifty-two operations, with three deaths, a mortality of just over five per hundred.

During the same period Meredith did fifteen operations, with one death, and Doran one operation, which recovered.

We have, then, during the past year, sixty-eight thoroughly

Listerian operations performed by three different surgeons, thereby increasing the mortality, with four deaths, just below six per hundred, against forty-three non-Listerian operations, performed by the same surgeons, with four deaths, just above nine per hundred.

To the candid mind, these results in ovariectomy and general abdominal surgery, taken from the statistics of a period of years, cannot but be convincing.

The pioneer work done at the Samaritan Hospital has had, and is having, its reward. Men, year after year, are appreciating more fully, as they understand, the great secrets of its success. Here great operators, from all parts of the world, have learned their first lesson in abdominal surgery, and have carried home, with them the knowledge which has led to still greater advance in this line of practice."

[The question of "success" in abdominal surgery resolves itself in the following question: Does *antisepsis* or *experience* in ovariectomies control the death rate? We firmly believe the latter the only reliable solution to the problem of recoveries, and when this branch of gynæcology is left to those who have properly qualified themselves for this work instead of every aspirant "taking a hand" just to see what he or she can do in this direction, the sooner our American statistics will reach those of our trans-Atlantic brothers.—ED.]

—THREE SUCCESSFUL CASES OF TAIT'S OPERATION.—These cases were the first of a series performed without the use of carbolic acid solutions for instruments and without the spray. Hydrant water boiled for six hours was used for the instruments and sponges in the first and second cases, and a solution of mercuric chloride (1 to 8,000) for like purposes in the third. The wounds in all three were dressed after the manner of Keith. The incisions were less than two inches in length. More than three months had elapsed since the operation in each case before it was reported. It seemed best to publish the cases in this manner, because the vast majority of all cases recover without accident from the operation, and hence mere statistics of the healing of the wound amounted to little but evidence of individual skill. Statistics of the real relief afforded by the operation was what the profession needed, in order to give the operation its just place in modern surgical procedures. The first case was in an unmarried woman, aged 32, with myofibroma, which gave rise to profuse and almost continual hæmorrhage. The tubes were found to be much thickened, and were distended with blood. The ovaries were enlarged, and the right one cystic. She lost no blood after the second day following the operation.

The second case was a married woman, aged 30, who for some years had been subject to attacks of unconsciousness, followed by epileptiform seizures at her menstrual periods. The operation was followed by immunity from the attacks, and the patient was able to do her work as well as before the supervention of the fits. The third patient was a girl of 19. Ever since menstruation began, she had suffered from constant dull aching pain deep-seated in the pelvis, the agony at times being unbearable. There were marked signs of general tuberculosis. Both tubes were as large as Bologna sausages, and both ovaries were cystic. Tubes and ovaries were matted in a mass of adhesions. Microscopic sections of the tubes showed colonies of the bacillus tuberculosis. The recovery was complicated by an arthritis, but she ultimately made a good recovery.—*London Med. Record.*

—LAPAROTOMY FOR DOUBLE HÆMATO-SALPINGITIS.—The patient was 32 years of age, and had been pregnant four times, the last about a year previously. In July, 1886, she had an attack of violent pain in the abdomen at the moment of the reappearance of menstruation after confinement, followed by hæmorrhage, which had continued ever since. Two months later she presented symptoms of general peritonitis with copious hæmorrhage. The attack has since been twice repeated at the menstrual epoch. On Sept. 20 she was admitted to the Salpêtrière. The fundus of the uterus could be felt above the symphysis, and the cervix was displaced forwards. The posterior *cul-de-sac* was filled by a tumour which could be felt also per rectum, but the upper border of which was inaccessible. The uterus was manifestly independent of the tumor. The case was diagnosed as one of hæmatocoele, with special features attributable to the uterine appendages. On Nov. 30, an exploratory abdominal incision was made. Behind the uterus was found a fixed spherical fluctuating mass, which could not be emptied by means of an aspirator. With much difficulty it was detached posteriorly and below from its adhesions. It was a mass of the size of two fists, with a large pedicle. When this was removed there still remained another tumor corresponding to the left Fallopian tube, consisting of pouches containing clot which had to be removed piecemeal; and on the right side a serous cyst of small size. The cavity left after the removal of the tumors was well washed out with boiled and filtered water, and packed with sponges to check the oozing. The abdominal wound was then closed without drainage. The patient went on very satisfactorily, and was able to get up for the first time on the eighth day.

—A NEW SERIES OF THIRTY-FIVE OVARIOTOMIES.—Twenty out

of the thirty-five cases presented difficulties of execution. They comprised twenty-six multilocular cysts, four peri-ovarian cysts, one dermoid cyst, one sarcoma of the ovary. Of the thirty-five cases, four operations were incomplete. Six patients died—three from shock or exhaustion, two from peritonitis in from one to five days, and one from latent suppurative peritonitis on the twenty-fifth day. Thanks to antiseptic precautions, not one of the sixteen patients operated on since Jan. 1, had died. M. Terrillon uses sponges rinsed in a solution of permanganate of potassium and kept in a solution of corrosive sublimate. He uses the spray beforehand in the operating theatre, but not during the operation. He employs the sublimate solution only for washing the hands and the abdominal walls, and carbolic acid only for the instruments; during the operation he uses nothing but water, boiled and filtered through a Chamberland filter, the quantity amounting to from 20 to 25 litres. It is to these precautions that he attributes his success, even in unpromising cases. After the operation he gives alcoholic injections per rectum, and after the second day, if the abdomen is tense, he gives three doses of three grains each of calomel. He gives no opium, and at most a hypodermic injection of morphine.

—BATTY'S OPERATION FOR PAIN AND HYSTERIA.—The patient, 33 years of age, was admitted to the Hôpital Bichat on Dec. 8, 1885. Father a drunkard. Had good health until 29 years of age. Married at that age, she had an attack of puerperal peritonitis. Her first hysterical attack took place eighteen months previously at a menstrual period, when she complained of suffering intolerable abdominal pain. No medical treatment rendered any service. She was operated upon on Feb. 9. The right ovary was easily found and ligatured; the left, which had contracted adhesions, was secured with some difficulty. After a series of nervous phenomena characterized by agitation and vomiting, the patient's condition very much improved, and she was enabled to leave the hospital on March 14. No menstrual flow before leaving.

—EXTRA-UTERINE PREGNANCY.—The patient, 27 years of age, had already given birth to a child. The present pregnancy had gone on all right until between the second and third month. At this epoch she had a good deal of abdominal pain. At term false labor-pains occurred, and extra-uterine pregnancy was diagnosed. Her condition, however, was such that it was only eight months later that the operation was decided upon. The incision, four centimètres long, was made above and parallel to Poupart's ligament and as soon as the integument was cut through the foetal

head was seen. Craniotomy was performed and the foetus extracted piecemeal, in order not to render it necessary to enlarge the opening further. The cavity was washed out with boracic acid solution, and a pre-existing vaginal fistula was utilised for drainage purposes. Recovery was rapid and complete.

—COMPRESSION OF THE URETERS BY A FIBROUS POLYPUS OF THE UTERUS.—The patient was a virgin, 39 years of age, who had suffered from severe cardiac symptoms with attacks of asthma and, finally, albuminuria for about two years. During the same period she had repeated attacks of hæmorrhage, accompanied or preceded by colicky (expulsive) pains. No vaginal examination had been made, and the diagnosis had therefore remained doubtful. The symptoms ultimately became so urgent that the patient allowed a thorough examination to be made. The result was the discovery of a dense fibroid polypus, measuring 6 centimètres by 5 centimètres. Its pedicle was inserted on the posterior wall of the cervix uteri. Examination per rectum made the localization and the delimitation of the tumor easy. The tumor was removed without difficulty by means of the *écraseur*, and the operation did not give rise to any hæmorrhage. It was not even found necessary to anæsthetise. The patient was quite well in a week. The interesting feature of the case was the compression exercised by the tumor on the ureters through the uterine walls, causing the reflex symptoms alluded to above. Within a short time after the operation the albuminuria, with the œdema and cardiac disorder, markedly improved, and finally to a large extent disappeared. The co-relation between compression of the ureters and the above symptoms has already been alluded to by Murphy, Fourestié, and Hanot, and last year Lancereaux showed that it was this that determined the fatal result in most cases of cancer of the uterus. His conclusions point to the necessity for a careful examination when women with fibroids present uræmic symptoms, to be followed by removal of the growth.

—ELECTRICITY IN THE TREATMENT OF TEDIOUS LABOR AND POST-PARTUM HÆMORRHAGE.—The patient was a primipara, 23 years of age. Twelve days before labor came on, Dr. de Fayette was engaged to attend her, and on examining her urine he found it contained a large quantity of albumen. When labor commenced her face was œdematus, pulse 110. Head presented in the first position. The *os uteri* was at first rigid, but gave way after a dose of 2 grammes of chloral-hydrate. Uterine contraction was feeble and ineffectual. After working twelve hours, a strong and rapidly interrupted current of electricity was brought to bear on the inert uterus. When the head came down on to the

perinæum the current was stopped. After delivery, as the uterus did not contract well, a dose of ergot was given. About an hour later the doctor was called hurriedly up-stairs and found his patient flooding. He at once passed his hand into the uterus, but did not succeed in setting up contraction; he then removed the clots and injected vinegar, but still no effectual contraction took place. The injection of hot water was equally in vain. The battery was then requisitioned, and with the positive electrode in the patient's hand, and the doctor holding the negative electrode in his left hand, he grasped the flaccid uterus through the abdominal walls with the right hand; the effect was instantaneous, the uterus at once becoming powerfully contracted and the hæmorrhage ceased. After a few minutes the current was discontinued and the bleeding did not recur.

—TRUE HYSTERIA CURED BY HYPNOTIC SUGGESTION.—The patient, consequent on peri-uterine inflammation, had the right ovary enlarged and painful, and grave symptoms of hysteria, for the treatment of which castration had been proposed. She was brought to the notice of Mr. Bernheim, who, after several séances, obtained a complete cure. M. Gron, whose patient she was, considered that in cases where grave nervous symptoms seemed to point to castration as a remedy, recourse to hypnotism should always be had before resorting to the operation. M. Bernheim thought that much of the good that followed castration in these cases was due more to the moral than the physical effect of the operation.

—EXPULSION OF THE UTERUS DURING LABOR.—Dr. Francisco saw the case in consultation (*El Siglo Medico*, January 30, 1887). A primipara, aged twenty-three, feeling the pains of labor beginning, examined and found the vertex presenting. The pains continued satisfactorily, when suddenly, after an intense pain, the whole womb with the child in it was expelled from the vulva, carrying with it the vagina. The cervix lay only two or three fingers' breadth above the knees of the patient. The os was only dilated to about the size of a shilling, and was very rigid. While the doctors were consulting, the patient had two pains, and the child was born; two deep lacerations having taken place on the left side of the os tincæ. The cord being tied, and the after-birth and membrane extracted, the womb and vagina were carefully replaced and a binder applied. The temperature marked $101^{\circ}3$ for the first two days, then became normal, and the patient made a capital recovery. The child was a female, living, and appeared of full time and strong.

—INCOMPLETE HÆMATOCOLPOS.—V.C., 16, domestic servant, first

menstruated a year ago, since when there has been a constant discharge of blood. She complains of general malaise and pain in walking. On examination, the hymen was found to be intact and completely closing the vagina. Blood was seen to ooze from two little capillary orifices; these evidently were not large enough to permit of the free egress of the menstrual discharge. An incision was made with the scissors, and a quantity of retained blood escaped. On the next day all discharge had ceased, and twenty-two days after the period appeared naturally.

—SIMULTANEOUS AUSCULTATION OF TWO FŒTAL HEARTS IN A CASE OF TWIN PREGNANCY.—Dr. Mayor records an interesting case where he was able to follow carefully the beats of two fœtal hearts. One head could be felt in the left occipito-iliac region, and to this corresponded a breech in the left hypochondrium. The other fœtus occupied a like position at the opposite side. By means of an arrangement resembling what is known in England as the differential stethoscope the phenomena could be best studied. At first the two sounds of a single heart were distinctly heard. Then these sounds became less and less distinct, and appeared to become distant. Then they were replaced by a sort of rumble in which it was impossible to distinguish anything clearly. To this rumble soon succeeded the sounds of one fœtal heart, at first somewhat distant, but gradually approaching in apparent nearness until they seemed quite under the ear, and becoming at the same time clearer and more sharply defined. Then there came the gradual indistinctness and seeming distance of the sounds, soon to be replaced by the distant rumbling, and which again in its turn yielded to the greater sharpness of the beats. These cycles followed each other with the greatest regularity. The explanation given by Dr. Mayor is that the two hearts were not beating synchronously, one going at the rate of 130 a minute, the other at the rate of 136. It follows that for several beats the sounds would almost coincide, whence the greater distinctness; and for several other beats the sounds of one heart would take place during the intervals of the other, whence the indistinct rumbling. This explanation received confirmation from an observation made on one occasion. One day the beat of a single heart only was heard, and that with great distinctness. Dr. Mayor inferred that the synchronism of the two organs was absolute. He tried, therefore, to hasten the beats of the hearts of one of the infants, and with this object made repeated pressure on the breech. The manœuvre was quite successful. The fœtus made some violent movements, the action of its heart was accelerated, and the phenomenon in question was displayed in a remarkably clear manner.

—ETIOLOGY OF "HOUR-GLASS" CONTRACTION OF THE UTERUS.—In the *Glasgow Med. Jour.*, March, 1887, Mr. Johnstone contributes a short paper on the subject of irregular contractions which sometimes occur in the middle and lower third of the uterus after the birth of the child, and before the expulsion of the placenta. The author gives his own experience of the use of ergot just before the child is born, and considers that in a great number of cases where "hour-glass" contraction takes place it will be noticed that this drug has been given before the birth of the child. For some time he made a practice of always giving ergot; when the pains were weak he gave it to hasten the birth, and when the uterus was contracting strongly he waited until, as near as he could guess, fifteen minutes before the birth of the child. Very shortly he had five cases of "hour-glass" contraction, and on reflection it was found that the "hour-glass" contraction had only occurred in those cases where the ergot had been given when the uterus was contracting vigorously. After this more caution was used, and during the next eleven years a case of irregular contraction was never met with. It is probable that ergot acts through the nerves of the uterus in an irregular manner, much the same as digitalis acts on the frog's heart. When the uterus is full, the most energetic fibres exhaust themselves on the expulsion of the child; but when comparatively empty, containing only the placenta, no check is offered to this irregular action, and hence the "hour-glass" contraction.

—SWEET SUMACH.—The fluid extract of the root-bark of the sweet sumach, *Rhus aromatica*, an Anacardiacea indigenous to the States, has lately been successfully employed in nocturnal enuresis of children. It acts as an excitant on the non-striped muscles of the bladder, the uterus, and of the inferior portion of the digestive canal, and beneficial effects have likewise been obtained from it in hæmorrhage of the bladder, the uterus, and the rectum, as well as in atonic diarrhœa. Dr. Unna recommends, from three years' experience, this extract in enuresis of children, for which it acts as a specific. He prescribes to infants and children, up to two years of age, five-minim doses in the morning and at bedtime; to children from two to six years of age, ten minims twice daily; and to older children fifteen minims twice daily. He never observed any injurious concomitant effects, even after its uninterrupted use during several months. Its tonic effects, however, are not permanent, the paresis of the sphincter muscles of the bladder returning soon after discontinuing the remedy. It ought, therefore, to be given daily as a rapidly acting palliative until the weakness has been gradually overcome by other adequate measures (training to the habit of regularly emptying the bladder, cold

baths, douches, cool beddings, etc.), and only then to be gradually withdrawn.

—DROPSY AND ALBUMINURIA IN PREGNANCY.—At a meeting of the Berlin Medical Society (*Deutsche Med. Wochensch.*, No. 9, 1886), Professor Leyden gave his views on this subject, which, however, met with considerable criticism from Virchow, among others, in the subsequent discussion.

Professor Leyden began by alluding to dropsy and albuminuria as symptoms of kidney disease in pregnancy. The former was known long since, but the latter has been duly appreciated only since Lever's celebrated work on the subject. Lever found albumen in the urine in every case of eclampsia in pregnancy, and therefore ascribed all such attacks to uræmia. It is certain, says Professor Leyden, that albuminuria in pregnancy is of more frequent occurrence than eclampsia, while, on the other hand, cases of eclampsia are recorded in which there was no albuminuria. Nor can any definite proportion be established between dropsy and albuminuria. The former is the more frequent, but albuminuria may occur without dropsy.

Now these symptoms, interrelated in some undefined way, point to a disturbance in the function of the kidney; and since Lever's theory has been known, particular attention has been given to disease of the kidney in pregnancy. Frerichs regards it as Bright's disease in pregnancy, and states that it soon disappears after it. As to the pathological anatomy, he states, without giving any special cases, that the condition of the kidneys varies greatly, there being either enlargement, or redness or paleness, or even granulation of the organ. Professor Leyden asserts that diseases of the kidney in pregnancy must be defined as a form caused solely by the conditions of pregnancy, and resulting sometimes in eclampsia. As other forms of the disease may also occur in pregnancy, the question arises as to diagnostic distinction. This is found chiefly in the development. Dropsy and albuminuria are developed in the second half of the *first* pregnancy chiefly. At first albuminuria is moderate, increasing until it reaches its greatest height at the time of labor. It then rapidly disappears. The urine is generally of normal color, sometimes bloody, and with either much or little sediment containing cylindrical forms, white cells, and more frequently blood-corpuscles, but with no material characteristics in general.

The question as to the state of the kidney during the process of the disease is a difficult one to decide, partly on account of the paucity of material at present at disposal, and partly on account of the diametrically opposite views of those who have examined the subject. Frerichs' view has already been given. Schroeder

says that there is no pathological change in the kidney. Professor Leyden considers Rosenstein and Bartels to be eminent authorities on the explanation of the process, but remarks that they differ widely in their views. The former first regarded the disease as engorged kidney, but in a subsequent edition of his work materially modified his views, owing to the researches of Professor Leyden. Bartels regards kidney-disease in pregnancy as belonging to acute parenchymatous inflammations.

Professor Leyden's researches have shed new light on the subject. One interesting case is this. The *post mortem* examination of the body of a patient who had died from eclampsia showed an enlarged pale kidney. Examined microscopically, it proved to be extensively charged with fat, particularly in the convoluted tubules, and to some extent in the glomeruli. The fat lay distinctly in large drops, not quite regularly distributed, which disappeared to a great extent on the kidney being kept in spirits for some weeks. The kidney was then found to be, even microscopically, nearly normal. In another case, the kidney was found to be enlarged and anæmic, being of a yellowish color. Microscopic examination showed fatty degeneration confined nearly to the glomeruli. Professor Leyden holds that the symptoms during life and the *post mortem* condition are best explained as resulting from long-continued arterial anæmia.

The origin of this disease is generally sought in the conditions of pregnancy. But beyond this point opinions diverge greatly.

The disease may become chronic, or it may assume the form of granular atrophy.

Schroeder's method of treating the disease by inducing abortion is not always safe; but must be considered in connection with the question how long albuminuria may last before there is danger of its becoming chronic, and what must be its intensity to give rise to fears lest it might continue after labor. The acutest cases are usually the most favorable, but those in which there has been albuminuria long before labor usually become chronic. It would, perhaps, be well to examine also more closely into the appearance of dropsy and decrease in urinary secretion. The first factor in the disturbance is, in Professor Leyden's opinion, the arrest of secretion in the kidneys, which generally precedes albuminuria and dropsy; and the continuance of these disturbances produces the anatomical disease of the kidney.

—TRACHOMA PUDENDORUM.—At a recent meeting of the St. Petersburg Obstetrico-Gynæological Society, Professor Ivan M. Tranovsky, of St. Petersburg, made (*Jürnal Akusherstva*, &c., January, 1887, p. 31) a highly interesting and instructive communication on 'Trachoma Pudendorum.' As is well known, Prof.

Sattler in 1881 proved that the secretion of a trachomatous conjunctiva invariably contained micrococci which differed from ordinary gonococci only by their comparatively smaller size. The same small microbes were found also in follicles, granulations, and their immediate neighborhood. Their cultivation and inoculation always produced a true trachoma. At the same time he found that when the gonorrhœal pus from the mother's genitals had been introduced into the child's eyes, it gave rise either to purulent conjunctivitis or to trachoma. In view of those facts Sattler came to the conclusion that trachoma had a gonorrhœal origin, the trachoma-microbe being only a 'mitigated' form of the gonococcus. Sattler's views were subsequently accepted by Arlt. Starting from the mycotic theory of the ophthalmic trachoma, Professor Tarnovsky states that, though the gynæcological literature does not contain a single word concerning the identical morbid process in the female genital sphere, there undoubtedly exists a 'true trachoma pudendorum,' as his extensive observations (mainly on prostitutes admitted with diseases of the vulva to the Kalinkinskaia Infirmary) have shown. In some cases, he says, gonorrhœal inflammations of the external genitals end in a complete recovery; but in some they do not. In such patients 'a careful examination of the mucous surface of the major labia, and especially of the upper commissura of the minor lips, detects isolated, slightly greyish or yellowish small nodules, of the size of a pin's head, surrounded by a slightly hyperæmic halo. They are usually mistaken for some prominent papillæ of the mucous membrane, or sometimes for comedones. Meanwhile, on watching their further fate, the following phenomena may be observed. In the course of time the nodules grow paler, though they remain raised; some of them subsequently disappear, while around others there come out fresh similar elevations, visible only by means of a magnifying glass. The latter nodules are grouped pretty closely. Later on, their number increasing, a group is formed, which has the shape of an oval patch, measuring 3 or 4 by $1\frac{1}{2}$ or 2 centimètres. Its epithelial layer thickens, roughens, and scales off; hence the surface of the patch acquires a velvet-like appearance. When examined by the finger, it proves somewhat harder than the surrounding healthy surface, and gives the sensation of sand being strewn under the mucous membrane. When the patch is scratched with the scalpel's end, a distinct crepitation is felt, and, in inveterated cases, even heard. The crepitation is not unlike that which is observed on scraping out follicles in the mucous membrane of the cervical canal, but somewhat softer and more delicate. The patch does not bleed either spontaneously or on touching. It bleeds but very little, even when punctured by the scalpel. Being superficially scratched with the latter, it becomes only somewhat moister.

When left without any treatment, the patches may persist for years, then increasing, and then disappearing at one spot to appear at some other. The remaining mucous membrane is sometimes slightly congested, sometimes unchanged; its secretion is usually of a mucous, but occasionally of a muco-purulent character. In old cases the granular surface of the patches becomes rough and hard, the mucous membrane dense. In very inveterated cases the whole surface of the patch is transformed into the cicatricial tissue, the mucous membrane being shrunken.

As the microscopical examination (by Dr. G. A. Tchoshin) shows, a patch of the kind represents an 'epitheliomatous papilloma,' consisting mostly of a dense connective tissue with numerous dilated capillaries, and of a thick epithelial layer, which in many places deeply embeds into the papillomatous tissue to form therein large follicle-like structures, surrounded with a thin amorphous membrane. The superficial epithelium cells are flat, small, horny, and densely packed; the intrafollicular cells are spherical, swollen, filled with mucoid (mucin) contents, their membranes being dense and thin, their nuclei well preserved. The new growth contains enormous numbers of micrococci, which lie within the epithelium cells (and which, according to Tchoshin, must be regarded as *the* cause of the process).

Passing to differential diagnosis, Professor Tarnovsky thinks that trachoma might be mistaken chiefly for milium, erosion of the papillæ, or granulating ulcer. The essential and almost constant symptom of trachoma is itching, which 'is felt deeply in the vaginal entrance.' It is not intense, and does not not cause any desire to scratch the parts. It decreases from tightly pressing the thighs together, pressure on the genitals, application of cold, introducing into the vaginal entrance cold and smooth objects (such as glass bottles, a knife's handle, etc.). It increases by night, in a warm bed, and (especially when trachoma is situated near the clitoris and over the edge of the minor labia) causes sexual desire, with tendency to masturbation. In some cases no pruritus is present, but only an increase of feeling and excitement during coition. 'The patients cured from trachoma sometimes assert that they consequently have lost, to a considerable degree, a pleasant feeling which they experienced formerly during intercourse.' They sleep always on one side, with their thighs firmly pressed together and drawn up to the abdomen. 'They like to sit or ride astride, or to drive in a shaky vehicle with soft, elastic, springy cushions.' Nothing of the kind is observed in cases of pruritus from prurigo, eczema, etc., or of senile itching. During the last seven or eight years Professor Tarnovsky came across sixty or seventy instances of a strongly pronounced trachoma, and about as many cases of an incipient affection. The disease was most

frequently met with by him in prostitutes, then in married women (during the first year of their marital life) who had formerly suffered from blennorrhœa or whose husbands had had gonorrhœa. In rare cases trachoma was found in girls aged 14 to 18; still more rarely it was seen in children 5 or 6 years of age; and four or five times in old women. The best treatment consists in a net-like superficial scarification (with a scalpel) and subsequent painting with a solution of nitrate of silver, or sulphate of copper or zinc (5 to 10 grains to 1 ounce of water), or with a 5 per cent. carbolic solution, or with a solution of sublimate corrosive (1 to 2,000). As a rule, trachomatous elevations begin to disappear within one or two days after the first painting, to dwindle away altogether after two or three sittings. In conclusion, Professor Tarnovsky states that trachoma pudendorum is infectious. He met cases of gonorrhœal urethritis in men, where the disease was contracted after intercourse with women suffering from trachoma without any purulent catarrh. He believes also that many cases of stricture and so-called endo-hyperplasia of the cervical canal, and follicular hypertrophy of the lips of the uterine as in women, as well as of strictures of the urethra in men, are caused by trachomatous vegetations in the mucous membranes of the respective organs.

—TREATMENT OF URETHRAL NEOPLASMS BY INJECTIONS OF CARBOLIC ACID. BY L. A. BALLARD, M. D., Lansing, Mich. Urethral neoplasms, urethral growths, vegetations and vascular tumors, are exceedingly distressing to the patient and often perplexing to the physician.

Those growths to which I think this treatment applicable are, cysts arising from occluded ducts, varices or overdistended venous radicles, and those vascular growths which Dr. Skene names Papillary Polypoid Angioma. The most common and most troublesome of these vegetations are the Angiomas or strawberry excrescences.

Skene says: "These growths consist of bunches of dilated capillaries set in a moderately dense stroma of connective tissue, and covered with mucous membrane supplied with the usual pavement epithelium, and are located very near or at the meatus."

Tait considers their chief histological characters to consist of an abundance of loops of capillaries, irregularly dilated and having very thin walls. Their recurrence is not the recurrence of malignancy, but appears to be rather the invasion of another though neighboring district.

Hamilton advises early and thorough excision as the most satisfactory treatment. Gross the removal by ligature or excision. Skene says: "The local treatment recommended by the various authors differs widely, but has the same end in view, *viz.*, the

destruction or removal of the abnormal growth. The various methods of extirpation employed are ligation, torsion, excision by the knife, scissors, curette, ecraseur, galvano-cautery, caustics, and electrolysis. A combination of means is best at times, say excision by the scissors and cauterization afterward."

Tait declares the only remedy to be removal by scissors.

Fritsch says the treatment consists in ablation, and proceeds to describe the operation with scissors and without subsequent cauterization.

Until the past six months I have followed the treatment universally recommended, and carefully excised the growth with scissors and cauterized the base with nitric acid, followed by strong solution of bicarbonate of soda. In January last I had under my care an elderly lady who had for many years suffered, with urethral irritation. At this time she had a mild attack of cellulitis, involving the anterior wall of the vagina, complicated by a not severe cystitis. In treating the bladder for the latter trouble, I found a bright red excrescence the size of a small bean, just within the meatus, but completely hidden by its folds. The growth was excised. The patient not being a good subject for chloroform, she was not anæsthetized, and being very nervous, would not tolerate a thorough operation. Three days later the growth had sprung up like a mushroom, and was one-half larger than at first, and now impeded the flow of urine. I tried to destroy it with nitric acid, but did not accomplish my object. The tissue thus destroyed one day, would reappear the next. I was about to run the risk of an anæsthetic and a clean excision, when I decided to make one more trial—this time with injections of carbolic acid. A treatment that had so simplified the removal of hemorrhoidal tumors, it seemed to me ought to be effective in these vascular growths, though I found no authority for applying it to this class of cases. I made a solution with thirty-three and one-third per cent. of carbolic acid, and using the hypodermic syringe, pierced the growth as near its center as possible, injecting 10 minims. After two days, found the growth one-half the size it was before the injection, and repeated the operation with the most gratifying results; for after a few days the site of the growth was as smooth and clean as any portion of the urethra, and remains so to the present time.

On May 3d, while treating a middle-aged lady, at my office, for uterine disease, I noticed a bright red excrescence the size of a small pea, but oval, peeping out of the urethra. The surface was as rough as a strawberry, and bled easily. The patient complained that something impeded the flow of urine, and that she had suffered for years with a great burning when urinating. I injected 10 minims of the carbolic acid solution, same strength as

before. Two days later I found the growth diminished, but not totally destroyed, and repeated the injection. Four days later the site of the growth still being rough, as I thought from diseased tissue, I again injected the same amount of the solution, with the effect of leaving the canal free and smooth.

I do not assume that these two cases illustrate the infallibility of the treatment, but they certainly bear witness that the carbolic acid treatment may be of great service in these sensitive and troublesome growths. Whether the recurrence of these growths will be so frequent under this treatment is a point yet to be proven. Considering that they are so liable to recur, and that the scissors or knife is an object of horror to many, and that these troubles so frequently arise in women of impaired constitution, to whom we would rather not give an anæsthetic, the simplicity of the treatment, and its comparative painlessness, is specially attractive. At the present date I have a case under this treatment in which the excrescence was the size of a large blackberry. I have operated with the injections upon it three times, and a small portion still remains. I protect the surrounding tissues with absorbent cotton saturated with glycerine.

In March last I was consulted by a lady who had for several months been annoyed by a small growth upon the integument of the vulva. Several times she had punctured it with a needle, pressed out the fluid contents, and for a time thought it had disappeared, but each time it filled it was larger than before, and the last time she emptied it the refilling had been very rapid. It was now the size of a large filbert. I drew away the contents of the cyst and injected the cavity with 15 minims of the carbolic acid solution. The growth disappeared, and to the present time has not returned.

In the transactions of the *Michigan State Medical Society*, (Allopathic), we find an interesting suggestion relative to the "relation between ulceration (?) of the womb and phthisis pulmonalis." The author of the paper, Dr. H. J. Chadwick, of Hart, Mich., starts out with the proposition that "as the soil must be in proper condition to receive and ripen seed, so must the lung-tissue be rich in the elements that bacilli live and grow in, or they must die. Their secretory surfaces must be abnormally changed before tubercular deposits can be made. It remains for us, as physicians, to determine what is the matter with the secretory and excretory organs that bacillus will be tolerated, or tubercular deposits allowed to form.

From a number of cases I have treated that had all the symptoms of phthisis, and recovered, and from a number I have seen others treat, and they died, with what they said was consumption, I am of the opinion that the majority of cases of consumption in women are caused by ulceration, evasion, or a general inflamma-

tory condition of the womb. Ulceration of the womb causes phthisis by weakening nerve force. Nerve force is weakened by conditions outside and inside the body—the outside influences are what the eyes may see, what the ears may hear, or the nose smell ; the internal influences are too much or not enough food, too much or not enough mental and physical exercise, excessive and not enough use of the passions. It is from these two latter causes, and abortions, that we are furnished with the most fruitful sources of ulceration of the womb. If the nerves regulating the heart, stomach and lungs are impaired at all by disease of any other organ in the body, no one can say but what in time they will be *ruined* by a continuation of the disease of that organ. Are they impaired ? I say yes. Who has not seen a nauseated stomach, tonsillitis, pharyngitis, and palpitation of the heart, that he could not see plainly that these symptoms were caused by derangement of the womb ? If it will cause a chronic inflammation of the throat, why, in the name of reason, will it not cause an inflammatory condition of the mucous membrane, a little lower down in the air tubes, causing the glands that keep this delicate mucous surface lubricated to become feverish ; causing their secretion to dry within them, just the same as the same cause would do in the skin, first causing a hardening of the secretion, which proves an irritant of itself, and afterward sloughing of the skin near it ?

—EGYPTIAN MIDWIFERY.—Although the Arabic language is, in a literary sense, an unknown tongue to me, yet I highly appreciate the aim you have in view in editing the *Shiffa*, which is calculated to raise oriental medicine to the status it had attained in ages long gone by. Since the closure of the medical schools of what may be styled the Arab age of learning, I fear Arab medicine has fallen into the background, and magic and humbug or superstition have taken its place.

From the time of Mohammed Ali, however, an honest attempt has been made, although by fits and starts, to elevate medicine out of the ignorance into which it had sunk. Hospitals and a medical school have sprung up as from the dead, and no doubt Egyptian medicine has thereby been rescued, in some measure, from ignorant and destructive charlatanism. No one who is at all conversant with the actual state of medicine in Egypt can deny that it is still in leading strings, and will continue to be so until political freedom is secured, and science and medicine allowed to stand on their own footing and to walk alone.

It is only in this way that we may ever expect to have teachers remarkable for their aptitude, and students full of enthusiasm. But in these days of advancement we have returned to the *corvée* in science, so that teachers and students alike may be said to be

driven to their work. The result of this is that the medical studies are finished without a particle of ambition to excel in the advancement of the profession, and the newly fledged doctors are sent to some out-of-the-way district ; and I may say all the districts are out of the way to him who understands nothing but Arabic and whose school takes no further interest in keeping him *au fait* with every advance in medical knowledge.

I consider, therefore, that the *Shiffa* bridges over a very serious gap in the medical education of this country, and I most heartily wish it every success, and I hope that ere long the authorities may recognize its usefulness sufficiently to keep its head above water.

The main object of the present communication is to bring under the notice of those whom it may concern the need there is for improving the practice of midwifery amongst the native midwives. Exodus 1 : 15-21. So far back in Egyptian history as 3,300 years ago there were midwives whose names have been handed down to posterity as famous for saving children alive, when their destruction was even ordered for political purposes. The secret main-spring of their actions lay in this, that they feared God more than they feared man, at the risk of losing their positions, if not their lives, and God made even their enemies to praise them ; for the powers that be are ordered of Him, and there is no wisdom nor understanding nor counsel against the Lord.

Now, if the Godfearing midwives of olden times saved many people alive, and thus were instrumental in building up a kingdom, what can we say about the native midwives of the present day, when they glory in executing their "ten craniotomies daily," making certain the destruction of the child, and in nine cases out of ten sacrificing the mother ? Surely this means the destruction of a kingdom. Why is it that Egypt, favored as she is by such a mild climate and peopled by such a prolific race, does not send forth colonies to people the earth ? The principal reason, no doubt, is the lamentable fact that the race is decimated by a system of wholesale murder of infants and mothers.

To prove that this language is not at all too strong I shall here relate a case or two that have come under my own personal notice, and no doubt other physicians can quote numerous cases that have occurred in their practical experience of a similar nature.

Only a few days ago a Turkish gentleman came to my surgery, begging me to come to the aid of his wife whose accouchement was being conducted by a native midwife. The pains of labor, he said, had been strong and frequent for the past twenty-four hours, but the child was not yet born. The midwife had told the family the child was dead and would have to be brought away in pieces, and that probably the mother would die. Such an alarm-

ing statement could not but call up the tenderest feelings of the family and make them cast aside for the time being their prejudices against male doctors. I was, therefore, called in, and the following is a short history of the case :

It was the lady's first accouchement. She was young, inclining to obesity and very strong. I found her seated on the usual oriental midwife chair, the midwife sitting on the floor in front of her and plying her heart. I purposely use this last word ; for, although midwifery is entitled to be called a science, it is certainly not known as such by the native midwives. I noticed that the pains were excessively severe, and, on examining the patient, with great difficulty made out a head presenting, and that it was still engaged at the brim of the pelvis. The vulva was very œdematous and swollen as only the vulvæ of native women can swell. The next few efforts of the patient were rendered less painful to her by the administration of chloroform. This soother of human suffering and facilitator of the accouchement is still foreign to the native midwives, so that they never use it in conducting their confinements, probably because they are not taught how to administer it in such cases, and there is not much chance of the rising midwives attaining this knowledge as I understand that the Maternity Hospital has been suppressed, and nothing substituted for it. Finding that no advance was made towards the delivery of the child, and that the midwife averred that the child was dead and that craniotomy should be performed, I proposed to try the forceps, and, failing with them, I told her we could still fall back upon other methods. The patient was now removed from the chair, placed on a bed and put thoroughly under the influence of chloroform. But while we were waiting for the forceps we had sent for, the midwife said that there was nothing for it but craniotomy, and she could not understand why I had set my face against it, as she said she sometimes performed this operation ten times in a day. I now had an opportunity of examining the abdomen of the patient, and found that the child was alive, which piece of information I communicated to the midwife, who probably did not believe me. I endeavored to pass a catheter into the bladder and so did the midwife, but we both failed, no doubt owing to the pressure of the head on the bladder, as it was now fixed in the brim of the pelvis. I made sure, however, that the patient had emptied the bladder only a short time before my arrival. The forceps were now applied, and with a little compression and extractive force the child was brought into the world apparently lifeless. A few seconds' suspension by the feet and a little slapping with the hands very speedily restored the suspended animation. While I was occupied with the child, I noticed that the midwife inserted her hand right into the uterus and brought away

the placenta, and this was done in such a nonchalant sort of way that I am convinced this is her custom. I have heard of such a practice being recommended by a California doctor at one of the annual meetings of the British Medical Association; but in the obstetric section of that Association he did not find a single supporter, and I am no advocate of doing any thing more than assisting nature when she is exhausted or when obstacles have to be removed out of the way.

The child was a female, which is looked upon as a calamity in a Moslem family, but they seemingly forget that if there were no females there would soon be a dearth of boys. Reflection, however, is not a prominent quality of the native mind.

The perineum of the mother was now examined and found intact.

I have been called to see the patient several times since the confinement, and I am happy to say that both she and the child are doing very well.

There is not the slightest doubt in my mind that if the midwife had been left to her own resources she would have performed craniotomy in preference to either forceps or turning, and would thereby have murdered the child that is alive and well to-day; and, as she told the family that the mother would in all probability die, no doubt she was speaking from her own dire experience. She rather prided herself in showing me the instrument she employed to perform this murderous operation.

Now, there would be little use in reporting this case unless some remedy can be proposed for mitigating or putting an end to such malpractice.

In the case above alluded to, it was the family that insisted on having skilled assistance. Had the midwife had her way, she would have gone on with her craniotomy and finished the case—and, in all probability, the patient too.

As long ago as July, 1878, I reported a flagrant case of malpractice to the authorities of the medical school at Qasr-el-Ainy, and as the midwife to whom the report refers is dead, it can do her no harm to lay the case before your readers, as it is a typical one and strengthens very materially the desirableness of carrying out some such suggestions as I have mentioned above. At that time there was no such medium of communication with the authorities as an Arabic medical journal, so the report had to be a private one, and names and details were given without hesitation.

I would recommend that all midwives who are discovered to be practicing their profession in such an ignorant way as to be a public danger should be reported to the head of the sanitary department, as well as to the minister of public instruction, with the view of having them not only called to task for their misconduct,

but also instructed afresh in any particular branch in which they have manifested their ignorance or culpable carelessness. This need not interfere with their daily duties, as they could easily spare two or three hours a week to attend a class at the school of midwifery specially gotten up for them, and which they should attend until the professor is satisfied with their proficiency. They might also be instructed to send for skilled aid, and without delay, when they find themselves in a difficulty.

Here, then is a copy of the report alluded to :

DR. SALEM BEY,

CAIRO, 6 July, 1878.

School of Medicine :

DEAR SIR : With reference to the case I mentioned to you this morning, I am now able to give you further particulars, and I hope you will see the necessity of preventing such occurrences as far as it lies in your power to do so. The facts are as follows :

Last night I was called to assist an Arab woman named "Ley la ahe el al el mulla" in the Esbekieh Quarter, who had been in the pains of labor three days, and was attended by a doctress of the name of "Amme." I was told that this doctress had broken the child's head and pulled off one of its arms, and that the instrument she used was an iron hook that she wrenched from one of the windows, and that the woman was still undelivered, and the doctress had left her saying she would return "on the morrow." I found, as I had been told, the forearm of a child with a cord tied round the wrist and some pieces of the parietal bones all together in a "tisht" (basin), the woman lying on the floor exhausted, undelivered, and the vulva œdematous and discolored, as if gangrene was about to set in. On looking into the vagina, I found the mucous membrane all torn, and the same gangrenous appearance presented itself. On passing the catheter into the bladder, a dark bloody serum passed, as if bladder and vagina communicated with each other. The mangled head could be felt in the vagina, and several sharp fragments of bone were piercing the vaginal walls. I carefully removed all these fragments, and after putting the patient under chloroform, I applied the short forceps and brought the mangled head into view, and in a few minutes the rest of the child was delivered. There was no narrowing of the pelvic diameters, the difficulty simply being an arm presentation, requiring the turning of the child for its safe delivery. Instead of that being done, a brutal system was adopted, causing the death of the child and probably also that of the mother. Finding that no progress was made, the doctress first broke open the head of the child with a barbarous instrument, which also lacerated the mother, and then she attempted to force the delivery by attaching a cord to the presenting arm and liter-

ally pulled it off. In England this doctress would be tried for murder.

I am, yours respectfully,

J. A. S. GRANT.

I may now mention that this woman's life was saved, but she had a large vesico-vaginal, as well as a recto-vaginal, fistula, for the treatment of which I sent her to the Qasr-el-Ainy Hospital, and gave her a letter giving a history of her case. I never heard any thing more about her, but I should think her case would be recorded in the hospital books.

Whether anything was done to "Amme" I don't know, but I consider that I fulfilled a duty in reporting the case to those who had the control of such matters.

SOCIETY TRANSACTIONS.

MISSOURI STATE HOMŒOPATHIC MEDICAL SOCIETY.

The following report of papers, relating to diseases of women and children, were presented calling out some very interesting discussions, of which we give briefly:

"The eleventh annual session of the State Society was opened by Dr. D. Kershaw, in an Address of Welcome, who referred to the rapid progress homœopathy had made in that section of the country, mentioning, especially the new Homœopathic College and Children's Hospital."

Dr. Moses T. Runnels of Kansas City then read a paper on the "Accurate Diagnosis in Uterine Diseases." He thought that the novice, after a sufficient practice in the study of the diseases of women, would be able to do with his fingers what before he could do only in an imperfect way with special tools. He had been greatly impressed some years ago by the skill displayed by the blind in the various branches of study and manufacture through their sense of touch alone, and he thought a gynæcological surgeon might become so expert in the same direction that his eyes would not be required to make a good diagnosis in many cases. Too much dependence upon the speculum and sound would not do, and prominent medical men were cited as authority for their danger, and the disuse into which they had fallen. Oftentimes filaments of nerves would be caught in the cicatrix of an old laceration, frequently causing neuralgia of other portions of the body. The danger was in being misled by reflex nervous symptoms, and in this way many physicians made mistakes. The skillful gynæcologist could not fail to detect any induration or fissures of the

cervix the moment his index finger came in contact with its vaginal portion. The bimanual revealed the character of fibroid tumors. Since the bimanual or abdomino-vaginal examination had been so well taught, the diagnostician required no sound to denote the depth or position, or to ascertain mobility or condition. The theory of many gynæcologists that nearly all the diseases of women had their origin in this organ would not hold good in practice, and thousands of the sex were victims of oversanguine doctors who never learned the truth except by great blunders. In the beginning of every case an accurate diagnosis was the all-important thing. All over the country physicians were undertaking to diagnose and treat such diseases, and the mistakes made were so frequent and inexcusable that the title of doctor had been shamefully dishonored. It was a lamentable fact that not more than one doctor in ten could make a semi-accurate diagnosis in any of these cases. As homœopathic physicians they needed to study physical diagnosis and pathology more. He did not wish to detract anything from what they had done in *materia medica*, but he pleaded for more thorough work in these departments of medicine, which had been so much neglected, and in which so much could be accomplished.

Differences as to Dancing.—Dr. Runnels was followed by Dr. J. Martine Kershaw, who read a paper on the subject of backaches of school-girls and young women. The common form of complaint Dr. Kershaw ascribed to the displacement of the uterus. He condemned dancing as generally carried on, stating that a delicate girl would often dance thirty miles in an evening. Sleeping on the back was also a prolific cause of this complaint, and he advised all to sleep upon the side or face. Appliances for removing the cause of suffering were discussed and recommended, and all girls advised to be careful of taking undue exercise. An active discussion of the paper followed, developing a great variety of opinions among the physicians present. Dr. Thorne spoke in favor of moderate dancing, saying that his sensations in dancing with a man would closely resemble those he would experience in waltzing with the traditional yellow dog. Dr. Richardson approved the paper because it provoked discussion. He heartily disagreed with every proposition advanced. Dancing in moderation was helpful, not harmful. Running up and down stairs hurt no one. More exercise, more pure air, and more healthful food were the remedies, not abstinence from dancing or local appliances. Dr. Parsons ascribed this sort of trouble to corsets, improper clothing and overwork at school. Dr. Kershaw closed the discussion by saying that he cared nothing for theory, but only cared to cure his patients, in which he had been reasonably successful.

Treatment of Diphtheria.—The first paper pertaining to clinical medicine was read by Dr. J. Martine Kershaw, upon the subject of the treatment of diphtheria. Dr. Kershaw's paper opened with the statement that diphtheria was a disease requiring vigorous treatment from the outset. As in the case of rattlesnake bites, it is of the first importance to treat vigorously before the patient's strength begins to fail. During an epidemic all suspicious cases should be treated as diphtheria, as the sore throat of to-day may become diphtheria to-morrow. Dr. Kershaw stated that as soon as he was called upon to treat a case of diphtheria he ordered whisky to be administered every four hours, in as large quantities as the patient can take without having the brain affected. After trying various remedies, the speaker said that he had found gelsemium and the cyanide of mercury was the best. The latter remedy had the effect of dissipating the old membranes and preventing the formation of new false membranes. The first-mentioned remedy does more than any other drug to lessen the paralysis consequent to many cases of diphtheria. These remedies are to be administered every two hours, day and night, no matter how much the patient may feel the need of unbroken sleep. It is necessary that the diphtheritic patient be fed well from the inception of the disease. Eggs, beef tea, soups and oysters are recommended. The sickroom should be light, and kept at the temperature of about 60°; carbolic acid and broma chloralum should be used as disinfectants. A gargle of alcohol and water is of great benefit in cleansing the mouth and throat. To this treatment nearly all cases will yield.

Opposed to Whisky.—At the close of Dr. Kershaw's paper, Dr. Edwards expressed his strong disapprobation of the idea of gorging the patient with food and fuddling him with whisky. The good effects of the latter in disease were mainly chimerical, and, except in rare cases, did more harm than good. Mrs. Wilcox believed in the occasional use of stimulants. Dr. Westover was deeply impressed with the ignorance of the assembled physicians upon the subject of diphtheria, which, in his opinion, was nearly always fatal. When a large proportion of supposed diphtheretic patients recovered it was a sign that they had not been suffering from diphtheria. Where the nasal passages were involved, he had never saved a patient. Dr. Edwards and Dr. Runnels followed, giving similar opinions. Dr. Carrier disagreed with the gentlemen who had just spoken, asserting that homœopathy could cure diphtheria.

After presenting many interesting papers relating to other diseases, of which, we as a special publication, will not report, the society adjourned.

The Guests and Entertainment.—Among those present were Drs. J. C. Cummings, S. E. Miles of Boonville, D. T. Abell of Sedalia, L. E. Whitney of Carthage, N. M. Griffin of Girard, Kan., E. A. Shirley of White Hall, Ill., Geo. W. Foote of Galesburg, Ill., W. D. Foster of Kansas City, and nearly all the St. Louis homœopathic physicians.

This meeting is considered to be the longest and most interesting yet held in the state. We wonder if the allopaths can see to read the "handwriting on the wall" when such successful reports of our society's meetings are recorded in the public print?

EDITOR'S TABLE.

By several months' editorial management of "*The American Homœopathist*," Dr. B. F. Underwood has ably demonstrated his ability to conduct a live and acceptable general Medical Journal that, from its character will not only add to the publishers income but shed lustre upon the name of the editor. The form of the journal has been changed, which is a decided improvement, and we congratulate Mr. Chatterton upon his good-fortune in securing so valuable a colleague as Dr. B. F. Underwood has thus far proven to be. We have no hesitancy in bespeaking for the editor and journal a hearty and generous welcome in the medical literary world and the profession.

—The "American System of Gynæcology" is almost through press and the first volume will soon be in the hands of the profession. We notice among the contributors to this great work Professors Paul F. Munde Geo. J. Engelmann, Fordyce Barker, Battey, Garrigues, Goodell, Reeves Jackson, Lusk, Reamy, Thomas, and Van de Warker. These names indicate that this work will contain a complete *resumé* of this great American specialty in its most recent aspects. The fact that it is being published by Messrs. Lea Brothers & Co., of Philadelphia, gives assurance that the mechanical execution of the work will be in harmony with its intrinsic worth.

—The Homœopathic Medical Society of Wisconsin will meet June 22-24, at Waukesha. Almah, J. Frisby M. D., is chairman of the Bureau of Gynæcology, assisted by Drs. Julia Ford, O. Sutherland, F. E. Storke, Delia G. Lyman. Subject: "Treatment of Uterine Disorders." Bureau of Obstetrics—A. G. Leland M. D. chairman, Drs. C. H. Hall, Isaac Buckridge. Subject: "Accidents and Diseases Incident to Labor."

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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No. 4.

JULY, 1887.

VOL. IX.

REFLEXES.

BY O. S. RUNNELS, M. D., INDIANAPOLIS.

(Read at the 21st Annual Session of the Indiana Institute of Homœopathy, Indianapolis, May 25, 1887.)

Sensation is the result of nervous impression and is either direct or indirect, as the cerebro-spinal or sympathetic systems of nerves are primarily acted upon.

Cerebro-spinal nerves are distributed chiefly to the external surfaces of the body, to the voluntary muscles and to the organs of animal life. They are connected also with all other portions of the system ; but the relationship is less intimate, and their characteristics are less pronounced than in the parts enumerated. They are distinctively the nerves of the will—reporting accurately all sensations of pleasure or pain and conveying the commands of the mind requiring motion. Like the muscles, they have periods of repose and are inactive unless called upon to report an impression or exe-

cute a command. This done, they relapse again into their state of quiescent vigilance.

The thing of marked prominence about the cerebro-spinal nerve is *definiteness*. With it there is never any doubt about *locality*. The report comes from the identical point where the impression is made.

Sympathetic nerves are distributed chiefly to the internal regions of the body, to the involuntary muscles, to the organs of nutrition and those mucous surfaces most destitute of sensibility.

They are endowed both with sensitiveness and motivity, but these properties are feeble and less active than with the cerebro-spinal nerves. But this is due to the decussation of small fibres from the cerebro-spinal, with the ganglia of the sympathetic—thus forming a connecting link between the systems and accounting for this motor-sensory property of the sympathetics.

Sympathetic nerves are distinctively the nerves of organic life, and have dominion over the involuntary processes of the body, to wit: respiration, circulation, digestion, reproduction and the various acts of secretion essential to health and growth. They are the equalizers of the life forces. Inasmuch as the constant maintenance of the organism depends upon them, they never sleep; but are in a continuous state of tension or activity.

The thing of marked prominence about the sympathetic, is its variant mode of expression. Unlike the cerebro-spinal or sensitive nerve, it does not invariably express itself at the point where the impression is made; but may call upon any nerve or nerves in the body, either sensitive or sympathetic, to voice its complaint. Indeed this is the rule of its expression. Its report of embarrassment and trouble may be looked for at some one or several distant points. Its flag of distress may be waved simultaneously by several of its neighbors and sympathizers, thus leading the uninformed to believe that several complaints are operating at once, and

that the organism, like the old "One-Horse Shay," is going to pieces all at once.

These distinctions between the two principal modes of nerve-action are of the utmost importance, and lie at the very basis of all correct interpretation of disease phenomena. Trained as we have been through all our lives to believe all that we see, hear, taste, smell and feel, and to follow every sensation of pleasure or pain to its definite productive-point we are often led to give undue prominence to the language of the cerebro-spinal system and to disregard or misinterpret the voices of the sympathetic system.

This is not so serious a blunder when acute diseases are under consideration, for there the warning is suddenly given, is definite and usually unmistakable. In the study of long lasting ailments however the Reflexes play a most important part and can not be misunderstood without disaster to both physician and patient. Particularly is this true of the manifestations of the sympathetic system of the abdomen—the so-called "solar plexus." This, as you know, binds in closest sympathy all the abdominal organs, the stomach, intestines, spleen, pancreas, liver, kidneys and generative organs. It has also an influence secondary, but not less pronounced, over the lungs, heart, brain and skin.

But of all the organs none have the ability to cast their burdens upon their fellows in so marked a manner as the generative organs and the rectum. It is because of the rich endowment of these organs with sympathetic properties that our search in this region is so frequently crowned with success.

In this brief paper I desire to direct your attention to some of these evidences and to emphasize the importance of their due recognition. I need not dwell upon the morning sickness and ptalism of pregnancy, and only mention them as pat instances of reflex disturbance. Neither shall I enlarge upon the multiform expressions of hysteria. In all these conditions we well know how nerves in and of them-

selves entirely innocent of disease presence are voicing the irritations and embarrassments of their kindred far distant.

These expressions are for the most part periodical and easily traced. Not so readily understood, however, are the causes of many long-lasting, oft-recurring protean diseases with which we have to deal—such as the recurrent neuralgias, the diseases of a periodical or term character supposed to be “hereditary” and denominated “spells,” and all those maladies of the blanket-mortgage kind.

A physician reports a case of neuralgia which yields promptly to his well-chosen remedy. No sooner though is the neuralgia cured than rheumatism is present. The cure of the rheumatism follows the neuralgia, thanks to “wise medication,” only to be followed by a bad case of diarrhœa, which, being “cured,” may be succeeded by liver complaint, skin disease, mental disturbance, insomnia, or any thing else ; until finally that badgered doctor wonders what will come next. He has an abiding faith, however, in his ability as a healer, and values most highly the services thus far rendered in “curing” the many diseases which have thus in a short, or even a long, time victimized his patient.

The points I make now upon such a service are : First. A correct diagnosis has never been made ; Second. No radical treatment has yet been administered, and, Third. Such a morbid kaleidoscope may be expected to revolve on till death brings release, or till some wise healer appears who shall search till he finds the embarrassed nerve which is thus in a hundred different ways crying for the relief which has never come.

I am exhausted of all patience as I hear or read the dazzling reports of such cases treated through months or years with remedies or tincture or Fincke doses.

My disbelief in the value of all such shallow procedure has finally culminated in the rankest intolerance.

Every such patient has been trifled with and has just grounds for complaint of malpractice.

His treatment has been but the superficial work of a beginner ; has been merely palliative and of no lasting value.

I trust the day will soon come when the back of Homœopathy will no longer be burdened with reports of that character ; and which, alas ! are, at present, all too frequent.

Hahnemann said, first remove the "Causa occasionatis"—do not attempt to deal with an effect until you have eliminated, if possible, the thing that is producing it. He first made painstaking endeavor to find and remove causes and never spent valuable time in searching for the "similimum" until he had done this.

For be it always remembered that somewhere a producer of every symptom—a cause for every *effect*—will be found.

ANÆSTHETICS IN LABOR.

BY B. P. MARSH, M.D., BLOOMINGTON, ILL.

I wish to urge a more general use of anæsthetics in excessively painful parturition. Not that I have anything new to offer, but that I would emphasize what has humanely *been* offered. I would exhort some to an unbiased reconsideration of their previous judgment, and present practice. I put the case this way, because, while I judge best never to attend a case of obstetrics without a supply of ether and chloroform, and in a majority of cases use them, I find that few of my colleagues have given their use a fair trial, in the manner that I shall indicate. I purposely omit reference to such abnormal cases, as render their use a conceded necessity. We certainly are all agreed that the use of anæsthetics is our duty in cases of convulsions, spasms of cervix, the operation of turning, application of forceps, perhaps, under some conditions ; and certainly in the more formidable operations that sometimes become necessary. But I refer to their use during the normal, physiological, but excessive, pains of parturition, merely for the relief of

suffering. The fact that many physicians object to this practice, is my apology for asking a few moments of your attention: For I believe that their objections are based upon a misapprehension of the effectiveness—and consequent safety—of a very small amount of an anæsthetic in such cases.

The suffering endured by the parturient woman is often beyond description; attest her agonizing cries, the contortions of every muscle of her face, indeed, of her whole physical frame, her suffering sometimes so intense as to cause her to beg for death, as preferable to such endurance. How comforting (?) the consolations of her physician, who patronizingly tells her, "This is all natural, madam; you can bear it." And hour after hour reiterates, "It will soon be over." And the dear old mother, and cousins, and aunts, chime in, "Yes, dear, we've all been through it; we know what it is; you can stand it; bear down; be brave, now; it won't take long; and then you will be so happy when you get through." The last of which statements is rather needless of argument. If patients or friends suggest the use of chloroform, the physician can easily convince them that "meddlesome midwifery is bad," chloroform dangerous, and nature equal to her task.

But I believe that continued intense suffering is generally unnecessary, that we can offer almost perfect immunity from pain, and that, too, with perfect safety, and even advantage to the patient.

And so I feel that in discussing this subject, I have a cause to plead. You, who so often witness the agony of "a woman in travail," and do not even as much to alleviate her suffering, as does the dentist to relieve his patient of the but momentary pain, caused by the extraction of a tooth,—hear me for my cause.

Often does this pain and suffering become, in itself, an obstacle to the progress of labor, retarding for hours, an otherwise rapid birth, because the patient "cannot bear her

pains." But, give her a few whiffs of chloroform, and how like magic all is changed! The uterine contractions, which before were short and fruitless, at once take hold with effect, and the case progresses rapidly, merely because the patient has been relieved of pain.

The main objection used against the use of an anæsthetic is its want of safety. The production of complete anæsthesia with chloroform or ether as is necessary in surgical operations, is undeniably fraught with danger. The surgeon and patient advisably assume this risk; and often for the most trivial operations where the pain is but momentary and light, as compared with the lengthened and intense suffering endured by the parturient woman. And the anæsthesia must be complete to render the patient oblivious to the sharp, penetrating pain of a surgical operation. But in the cases which we are now considering, the inducing of complete unconsciousness is entirely unnecessary for relief. The heavy contractive pain of parturition is quite different from that produced by the keen, stinging cut of the surgeon's knife. And it is often possible with a very small quantity of chloroform to produce a state, in which the patient becomes nearly or quite unconscious of suffering, while she still is more or less sensible of uterine contractions. Indeed, a few drops of chloroform, or at most a quantity so small as to scarcely affect consciousness at all, will often be sufficient to so dull the edge of the pain, as to practically relieve all suffering.

Those who deny the practicability of producing, during labor, a semi-anæsthetic condition, compatible with a consciousness that is nevertheless insensible to the pain of uterine contraction, do so, I think, on theoretical grounds. Clinical trial only can decide this.

In my own practice, when labor is quite well advanced—often earlier—and the pains are very severe, and the patient, in my judgment, for this or any other reason, demands relief, I fold a newspaper funnel shape, and upon a napkin placed

within this I pour, from a few drops to about one-half drachm of chloroform and ether; or if patient be not very plethoric, sometimes a mixture of chloroform, ether and alcohol is better. Allowing her to take several inhalations of this, I then direct her to take same number of deep inspirations of air. Thereafter, at frequent intervals, I repeat the application of a very small amount of the anæsthetic, as I find sufficient to produce a semi-unconscious state. If the inhalations are infrequent, quite slow and progressive, and a very small quantity used, any danger of untoward effects can be entirely avoided.

Ordinarily, from ten to fifteen minutes are required to produce the condition desired. I never give enough but that the patient will readily respond to questions. And indeed this is my test of the border line of consciousness over which I would not have the patient pass. Often the patient may thus be engaged in a continued and connected conversation, and she will appear to be cognizant of all, or much that is transpiring in the room, will apparently notice and bear down with the uterine contractions, but after all is over will declare that she felt little or no pain; in many cases even the last throes and expulsion of the child are painless, and sometimes she is not aware that her babe is born until told of the fact, and yet she was talking intelligently all of the time. This is accomplished by giving very small quantities of the anæsthetic at intervals; especially just before and during the pains. This I never trust to an attendant. The attendant merely applies and removes the funnel containing the chloroform, at my direction; when not applying, keeping it closely pressed to the bed or pillow, to prevent its contents escaping to the atmosphere of the room. The anæsthetic I keep within my own reach and pour a proper quantity into the funnel often as needed, my guide being, as before stated, the readiness of the patient to intelligently answer my questions.

Sometimes it is possible and more satisfactory to lead the

patient off into a hallucination of events, such as an excursion into the country, a visit to friends, or an attendance upon some unexpected concert or opera. In such cases, the effect is novel, the deception complete, and the patient has afterwards the recollection of only a pleasant dream.

To produce this happy effect the chloroform *must* be perfectly pure. This is absolutely essential. Seldom will one satisfactorily succeed in producing and maintaining a semi-anæsthetic condition with ordinary chloroform. And in accomplishing this there is no necessity nor excuse for pushing the anæsthetic beyond the line of safety.

Let us not forget that the danger of chloroform consists in its depressing effect upon the heart. But in the parturient woman the condition of the heart is that of intense over-excitement. The patient's excessive muscular exertion, and mental agitation produces the rapid bounding pulse; the blood vessels of the brain are turgid and full. These conditions are protective against the depressing effect of chloroform. In the surgical patient the conditions are usually far otherwise; the muscular system is relaxed, the heart is already depressed. Fear and anxiety in anticipation of the operation has caused a weakened circulation and depressed mental condition, and the administration of an anæsthetic must be more or less fraught with danger. Not only are the conditions in labor, protective against the dangers of anaesthesia; but, furthermore the anæsthetic used cautiously and with skill is a safety check against this same over-excitement of the circulation. By calming and quieting the heart's action, the brain is relieved of the undue blood pressure, the danger of convulsions lessened, and nervous excitement quieted. Statistics show a surprising freedom from fatality in the use of chloroform in midwifery. This is a recognized fact, and it must be remembered too, that the statistics are, quite entirely, of cases of complete anæsthesia, a use we are not now advocating.

The physiological changes of heart and vascular system

during gestation are also a protection against the unsafety of chloroform. These changes are well known.

"The heart becomes hypertrophied, the venous system becomes enlarged by the distention of existing veins and the development of fresh venules. The quantity of blood is increased. When chloroform produces fatal syncope, it does so by its depressing action on the heart. The weaker the heart the more readily does it succumb to the paralyzing action of chloroform." This is well known. When, however, the heart is strong, stronger than usual, as in the hypertrophied heart of pregnancy, it can the more easily withstand the action of chloroform.

That in such a procedure as I advocate there can be no harm to the child is a recognized clinical fact; even in cases where the mother has been kept in a state of complete anæsthesia for many hours, the child has generally shown no signs of ill effects.

I affirm that the use of chloroform during labor is entirely safe if given in the manner described.

Why not then relieve every parturient woman of pain? why not make the experience of opening motherhood a delightful dream instead of a night of sorrow.

In these days when luxury and wealth seek, by all sorts of means, to avoid maternity, on account of its pains and cares, it is of no small moment, if we can rob parturition somewhat of its terrors, and thereby persuade mankind to better things. I am thankful to have saved, at least a few of the innocents, yet unborn, by my promising the mother that she should have a painless labor.

It had been urged that chloroform predisposes to post-partum hemorrhage, I believe this objection has been given undue weight. I have long used it in the manner above stated, and have never met with this inconvenience where I thought of the effect of the anæsthetic, when used in small amount, I doubt if it has this effect in any appreciable degree.

I have frequently attended women who informed me—as a matter of caution—that they had suffered from severe hemorrhage after previous confinements; I nevertheless used in their cases ether and chloroform, and with no undue hemorrhage following.

It is also claimed that anæsthetics lessen the uterine contractions, make them less effective, thereby prolonging labor. This might be the effect if complete anæsthesia were produced, but certainly not when the patient is kept only in the semi-unconscious state. In some cases the pains are delayed a few moments, but in a short interval they return, and often with renewed vigor. The rest obtained by the patient between labor pains contributes to this; and in cases where the woman is much fatigued, and in a hyperæsthetic state from a protracted labor, the effect is quite certain to strengthen uterine contractions and shorten labor.

The patient not suffering from pain, bears down with the uterine contraction throughout its entire continuance. The contractions are increased not diminished, are longer, more effectual; labor is expedited; and a case is soon terminated, that had threatened to be a long tedious labor. Even its early employment sometimes accelerates rather than retards labor; and the acknowledged objection to chloroform as usually administered, when applied to the use I am now advocating, become theoretical allegations rather than established facts.

How often does the physician sit by and wait for “nature” to battle in a long struggle with an undilatable os. Labor pains are strong, but entirely inefficient against this unyielding barrier. The patient exerts all her physical strength until the perspiration rolls from her forehead, and the blood vessels of face and neck stand out and pulsate as if they would burst. The constantly recurring pains bring about a condition of hyperæsthesia and nervous irritability, almost unendurable.

Finally she is out of heart, out of strength. Friends are

impatient, the doctor is embarrassed, and indicated remedies entirely inert.

Give such a patient a few inhalations of chloroform, and it will act like magic. Pain is allayed, the patient is at rest, the os relaxed, the efforts of the patient go on the same as if no chloroform had been taken. A forward movement immediately commences and labor progresses rapidly.

Another desideratum, of great moment, is accomplished. The accident of laceration of the os has been prevented, which in such a case could otherwise hardly have been avoided.

I think no one will question the acknowledged fact, that when the child's head is pressing upon the perineum and passing the vulva, especially when the perineum is tense and resisting, chloroform causes that organ to relax, and lessens the danger of its rupture.

In most cases the ordeal of childbirth is exhausting and depressing to both the muscular and the nervous system. During a few hours a woman in perfect health, has been reduced to a condition of extreme fatigue, and almost helplessness, in which state she must lie for days, or even weeks. The universal clinical fact is that these incident conditions are all ameliorated by the use of chloroform. The patient wakes from her dream with but little fatigue of body or mind; the resulting soreness of uterine and abdominal muscles is incomparably less. There has been a conservation of physical forces, and she has a rapid convalescence.

Let me also call attention to the sad accident that statistics tell us sometimes happens. A long, tedious labor may have progressed to an apparently favorable termination, but the patient suddenly sinks into a condition of fatal nervous shock. Such a result could scarcely occur under the judicious use of an anæsthetic.

I do not wish, by any means, to be understood as advocating an indiscriminate use of chloroform. Many patients do not suffer extremely; others are very brave to endure,

and of course anæsthetics are then uncalled for. The good judgment of the physician must determine in each individual case. Also, in most cases of extreme exhaustion it would do harm, weaken the action of the already weak heart, lengthen labor, and prolong convalescence. We should not use it in anæmia, uterine inertia, or at any time when the patient would not suffer without it. When labor is complicated with acute heart or lung disease, it should seldom be used, only under necessity, and with greatest caution; also if there be suspicions of a fatty or enfeebled heart wall. But in some cases, even, of heart lesions, the anæsthetic may become an agent of safety, not of danger. For the patient's great muscular exertion excites the heart to an intensity of action that it cannot safely endure. An anæsthetic calms and controls this undue excitement, and when administered with judgment and skill, is a positive benefit, often, to the heart. This I have tested in several instances.

On the other hand, what are the indications for the use of this great boon? They are mostly summed up in one word, *pain*; and when that is really and intensely severe; no matter in what stage of labor, or what the cause; it may be from a rigid os, tension of soft parts, irregular contractions, an apprehensive state of mind under nervous excitement, or excessive uterine contraction. When the patient would suffer extremely without it, I give her the relief afforded by an anæsthetic, administered in the manner and under the restrictions above stated.

And for the following reasons, viz.:

That the condition of the pregnant woman who has approached the time of confinement, and especially her condition during parturition, are protective against the usual dangers of an anæsthetic.

That the dangers to the child are none.

That the tendency to produce post-partum hemorrhage has been greatly exaggerated, and so far as it exists is easily controlled.

That the certain tendency claimed by some to lessen uterine expulsive contractions, is not in accordance with clinical facts, and that in many cases the opposite effect is produced.

That the condition of partial anæsthesia being sufficient for almost complete amelioration of pain, our object is accomplished with entire safety.

That in a majority of cases, where its use is indicated, the duration of labor is shortened.

That the danger of laceration of the cervix, and more especially laceration of the perineum, is materially lessened.

That in cases of suspicioned heart-lesions the anæsthetic, which ordinarily is a dangerous agent, often becomes to the parturient woman her anchor of safety.

That the occasional deaths from nervous shock will undoubtedly be entirely avoided.

That by thus lessening the terrors of childbirth, it is a moral persuader.

GYNÆCOLOGICAL NOTES FROM NEW YORK POLYCLINIC.

BY J. E. WELLIVER, M. D., RUSHVILLE, IND.

(Read at the Twenty-first Annual Session of the Indiana Institute of Homœopathy, Indianapolis, May 25, 1887.)

Prof. Mundé in speaking of Sterility gives as causes: 1st, Displacement of Uterus. 2d, Conical shape of os. 3d, Lacerations and leucorrhœas.

When mouth of womb is displaced, he thinks the germs fall into cul-de-sac of vagina and thus fail to come in contact with os and hence fail to get within the womb.

Treatment recommended was correction of the displacements, dilatation of os three or four days before menstruation and connection for conical cervix. Repeating the dilatation every week or so, until successful or convinced

that it was not the proper method of treatment in this case.

He closes lacerations after treatment with cotton tampons, saturated with glycerine, upon which iodoform is freely sprinkled. Hot water irrigations are recommended.

For endocervicitis and endometritis Prof. Mundé recommends iodized phenol, also chloride zinc, 13 to 13 water applied to endometritis by aid of cotton-wrapped probe through speculum. He prefers the tupelo tent to dilate os for permanent effect before curetting and applying nitric acid or iodine after curetting.

Prof. Sims replaces retroverted wombs by aid of Sims' repositior, and believes in keeping them in position by some form of pessary. Any form that answers the purpose and that can be retained by patient without detriment. Advises great caution in the use of any intra-uterine stem pessary, and insists on not applying any stem pessary in any patient and allowing them to go beyond your reach before twenty-four hours have passed, and in case any unpleasant symptoms or pain is produced remove the instrument at once; he always instructs his patients to remove any pessary when beyond his reach if it at any time causes pains.

He recommends in some cases, where the first operation for lacerated cervix fails to remove all symptoms he believed to be due to the diseased tissues which he failed to completely remove at first operation, a second operation consisting of removing all the tissue around inside of os. Introducing a plug to keep a canal open before closing up the womb, and leaving it there until other part is united, afterward regularly dilating the canal with his dilators until there is no tendency to contract. I believe he and Prof. Emmet both claim to have first performed this operation.

Prof. Sims recommends and uses in a class of cases he finds among his female patients (and he has not had a male patient for seventeen years, he says) who are unable to retain their urine any length of time, day or night, on account

of insufficient capacity of bladder, brought about mostly from cystitis and consequent thickened mucous membrane of bladder, injecting warm water daily to the fullest capacity of the bladder. He finds his patients begin to improve immediately and each day is able to inject a little more. His limit of amount each time is tolerance of the patient, not causing her too much suffering. If at any time it comes to a stand-still before the capacity of a pint is reached, he continues at that until he succeeds in injecting sixteen ounces which he considers quite successful. The treatment is kept up for some time at longer intervals as the symptoms of patient demand.

Prof. Wylie considers the aetiology of almost all female diseases to be due: 1st, To imperfect development of uterus. 2d, Miscarriage and labor. 3d, Venereal diseases.

He teaches that if the patient has pains preceding menstruation, she may have an ovaritis or salpingitis, and if no pain no probability of either of these diseases. To cure painful menstruation not due to ovaritis or salpingitis, dilate cervix twice a month. To cure painful menstruation due to ovaritis or salpingitis, recommends cotton tampons soaked in solution, 1 part boro-glyceride, 1 part pulverized alum and 14 parts glycerine.

He allows tampon to remain twenty-four hours and repeats in three or four days, and in the interval recommends the hot water irrigations. If the ovaritis or salpingitis goes on to formation of pus and there seems to be no possibility of removing the disease, he recommends removal of diseased parts by laparotomy, under the most approved antiseptic precautions. For sleepless patients he recommends eating four times a day. He thinks there is less danger from operation for removal of diseased ovaries and tubes than from forcibly tearing up old adhesions that bind the uterus down.

If he opens an abscess of pelvis and finds fetid pus, he washes it out with bichloride solution 1 to 2 or 3000, then

when it is clean puts in a probe without a handle and passes over this a dilator, and when in opening made by trocar in opening abscess, stretches to fullest extent, then inserts a drainage tube through which he washes out abscess subsequently ; stitches tube fast to cervix uteri. When this stops running and heals takes out diseased ovary and tube which he considers always exist.

Opens abscess on back, passes probe while on back, then turns in Sims' position, passes Sims' speculum, then dilates and passes drainage tube over probe, after dilating opening.

Prof. Wylie objects to *suddenly* and forcibly tearing up adhesions with uterine repositors to restore a displaced womb, preferring instead its gradual replacement by aid of cylindric form tampons saturated with boro-glyceride solution, which act as a support. Has not so much use for pessaries as some others, and none for stem pessaries.

He examines his lying-in patients two weeks after confinement, and if he finds the womb too large, commences use of boro-glyceride tampons twice a week, and if, after six weeks' treatment, finds the womb subinvolved or retroverted, dilates uterus and ascertains the cause, which is usually due to fungus growths, polypi, or endo-cervicitis or metritis, and which can only be cured by curetting the womb and removal of offending and diseased tissues. For anteflexion he dilates uterus with his steel dilators, and after dilating applies pure carbolic acid through his cervical protector, then dusts iodoform on os and in vagina with powder-blower.

He believes dysmenorrhœa to be due four times out of five to hyperæsthesia at os internum and not to diseased tubes and ovaries. Periuterine inflammation causes hæmorrhages. Hot flashes and other nervous manifestations during climacteric he believes can be overcome by first a six weeks' course with the boro-glyceride and alum solution on cotton tampons, then dilating uterus and making thorough application of pure carbolic acid once a week for three

weeks. And he recognizes this same treatment for dysmenorrhœa. The dilatation, etc., may have to be repeated every three to six months for some time during the climacteric.

Prof. Hunter, to stop hæmorrhage temporarily from womb, recommends ordinary cotton tampons soaked in saturated solution ferri-alum, few wet pledgets only needed to and around os, then cover with more dry common cotton and apply T bandage. Will stop any hæmorrhage.

Dr. Coe uses equal parts tincture aconite and Churchill's Tr. Iodine to erosions of cervix then applies the glycerine tampons. He finds galvanism of great benefit for pains in pelvis, supposed to be due to ovaritis, adhesions, etc., about uterus, and also where removal of ovaries and tubes seems to be the proper treatment. Finds that closures of lacerations do not always relieve the pains supposed to be caused thereby and afterwards uses the galvanic current with frequent relief.

Dr. Grandin is equally loud in his praises for galvanism for cellulitis, and especially to those cases that resist the glycerine and hot water treatment, and to all cases of supposed adhesions, and to all cases upon which operations have failed to remove the pain and tenderness in pelvis, applying a current as strong as patient can bear, 14 to 20 cells, with positive pole in uterus and negative over tender spots.

In the use of the glycerine and hot water treatment all agree as to its usefulness and method of applying. Using the tampon from every twenty-four to ninety-six hours, allowing to remain from twelve to seventy-two hours, and while it is away using the hot water irrigation with the patient lying on her back with elevated hips, and using every twelve to twenty-four hours, from one to three gallons of hot water, temperature from 105° to 115°.

The whole treatment is wonderful in contrast with that of the caustic treatment of twenty years ago, and still indulged in by many who fail to keep up with advanced methods.

Dr. Emmet goes so far as to claim 'all diseases of womb

not requiring operative treatment can be relieved by applying medication as seems indicated to vaginal surface alone, and uses no intra-uterine applications.

THE TREATMENT OF ACUTE CAPILLARY BRONCHITIS.

BY H. W. CHAMPLIN, M.D., CHELSEA, MICH.

It is not our purpose to write a paper on this subject embodying the universally accepted opinions of the profession. If there are any statements made that will draw out a contrary opinion and a profitable discussion, this paper will have fulfilled the object of its writer.

Having had a large number of cases of this disease under treatment during the latter part of winter and early spring, it occurred to me that it might be a profitable subject for discussion. We will only refer to symptoms sufficiently for an intelligent consideration of the treatment.

First let us understand that, while we may not be able to make a clear-cut diagnosis in every case in practice, we can describe what we mean by capillary bronchitis. Although the name has been made for the disease, and not the disease for the name, yet it does not indicate the full pathological condition existing in actual cases. Acute Bronchiolitis is scarcely an improvement except in brevity. Catarrhal Pneumonia is used synonymously. Broncho-Pneumonia has a pathological signification.

Where we talk to our patients we often speak of the disease as Inflammation of the Lungs, a very plain though very indefinite nosology. Allow me to suggest here that we be thorough and accurate in rendering our diagnosis to patients or friends; while we are treating a case under one name, or possibly without a name, our competitor will come along with a high-sounding, though equivalent diagnosis, and steal a march on us.

In the disease generally called Capillary Bronchitis, we have not only an inflammation of the mucous membrane of the smallest bronchi, but also an inflammation of the alveoli and peribronchial tissue, which may extend to the pleura. Thus we have a catarrhal inflammation and a pneumonia, as the name catarrhal pneumonia suggests.

The disease is of greatest frequency during the first year of life, and diminishes progressively to the fourth year. Exposure to cold is a prominent cause, although this disease may be secondary to acute catarrh of any part of the respiratory tract. The writer has had many cases following whooping-cough during the past season. It is often a serious complication of measles. The catarrh accompanying dentition often assumes this form in winter. All of these causes must be taken into consideration by the Homœopathic prescriber.

The indications for treatment are, in the first place, the high fever; the temperature rises rapidly to 104° and may reach 106° F. The pulse increases to 180 or 200 per minute, but the increase in respirations is out of proportion to the pulse, being often as high as 100 per minute. The coughing is frequent, dry, painful and ineffectual; mucus that may be coughed into the throat passes into the stomach. Prompt relief from the accumulation of this mucus in the lungs and stomach is, by some, considered an important indication for treatment.

The bronchial muscles are weak and no voluntary effort is made to clear the bronchi and the mucous exudation accumulated in the lungs.

If the disease be not arrested or greatly modified by early medication, we have for treatment, great exhaustion, a weak pulse, the stupor of carbonic acid poisoning and sometimes convulsions, especially when complicated with dentition.

Allopaths claim a mortality of thirty-five to fifty per cent. under their treatment. We do not know what the result is under Homœopathic treatment, but we are sure the mortal-

ity is much less; it has been so in our own experience, at least. We speak of the allopathic treatment only as a warning, recommending that it never be followed. German and English writers, except Ringer and Philips of the old school, recommend quinine and all of the heroic treatment suggested by that name. The older writers and practitioners of this country follow the same plan of treatment, and meet with a mortality often reaching fifty per cent. In a case recently coming under our treatment, the attending physician had been giving quinine for a week, and told the parents that there was nothing else but quinine for the child. We found the capillary bronchitis, complicating the process of dentition; temperature 106° , and a tendency to convulsions. The child recovered. It is in dentition with a tendency to spasms that we consider quinine especially dangerous.

Was visiting a case of Phthisis Pulmonalis in a neighboring town, and while there was called to see a sick child. The case was one of capillary bronchitis occurring during the process of dentition. Belladonna was administered, and the parents reported in a few days that the child was all right. In a day or two from this report the child was taken worse, and a local physician called in; quinine was given, and death speedily followed.

There is a class of physicians of the old school that are more modern and progressive. We know from experience that they are strong competitors, because of their modified treatment. With their aconite and belladonna and adjuvant treatment, they are meeting with a mortality of much less than fifty per cent. Prof Wm. H. Thompson of New York, in his article on Capillary Bronchitis in "Buck's Handbook of the Medical Sciences," has the following on treatment:

"As soon as the thermometric rise and the symptoms indicate the threatening approach, the aim should be to shorten the acute stage of inflammation as quickly as possible. For this purpose aconite is the best medicine and should be given with the set determination to make the patient feel it."

Characteristic of his school he recommends its being pushed until brandy is necessary to counteract the depressing effects of the medicine. After a multiplication of words extolling the virtues of aconite, Professor Thompson recommends belladonna in full doses, to be continued until convalescence begins. With the exception of citrate of potash and nitrous ether which he recommends, this so far simulates Homœopathic treatment. Some of the treatment which he afterwards mentions is not necessary in good Homœopathic practice. The empiricism of Prof. Thompson and many others of that school has resulted in a treatment much more successful than the ordinary Allopathic. Will not this modified Allopathy which is a crude imitation of Homœopathy be the practice of the rising generation of Allopathic physicians? Will not the success of this improved though crude method of treatment so approximate the superior results of Homœopathic practice, that it will be difficult to demonstrate our superiority to the people.

Prof. Thompson says, quinine is given in pulmonary inflammations with the same regularity at present as blood-letting was resorted to a half century ago and *with no better reason*. While a physician following the empirical treatment of Dr. Thompson will have fair success we can do still better. The law of cure will help us out when a physician following the above narrow range of treatment must inevitably fail.

If we see the case early enough aconite is the first remedy in uncomplicated capillary bronchitis. In cases following or complicated with whooping-cough, measles or other disease, a constitutional remedy as sulphur, calc. carb., etc., is indicated; a single dose may be sufficient, followed by aconite, belladonna or bryonia, or the antipsoric may need to be continued.

When this disease is complicated with the process of dentition, we often give belladonna first and all of the time. In our practice bryonia has afforded relief like magic when

the cough is worse from drinking and followed by gagging and vomiting. When complicated with whooping-cough, drosera or hyoscyamus will be often indicated by the usual characteristic symptoms of those remedies. If the inflammation be extensive in the parenchyma of the lungs, characteristic symptoms will frequently call for phosphorus. Arsenicum and mercury are often indicated by their well-known symptoms. For the stupor occurring late in the disease, opium has been very useful. By not mentioning ipecac, tartar emetic and other valuable remedies we do not mean to ignore them, but our experience has been chiefly confined to those already mentioned. In regard to the use of material doses of opium, we quote again from "The Reference Hand-Book of the Medical Sciences."

"When the struggle for breath once begins in deadly earnest, the indications change to the two purposes of supplying oxygen, and of sustaining the patient in the dread struggle.

Why should the necessary restlessness of the patient be now smothered by opium. It is difficult to see any reason for the employment of this drug, from first to last, in this critical disease, other than that of securing the deceptive quiet which this most effective paralyzer of respiration may occasion in bronchitis, preparatory to a quiet forever permanent.

Great relief and permanent benefit may be obtained by inhalations of pure oxygen gas. The supply of pure air in the sick room should always be good.

When we are called to these patients we often find them daubed and smeared with every thing nauseous and disgusting. Many times nurses and friends will not be satisfied unless the local application of such vile mixtures be resorted to. In the early stage a jacket of wadding, covered with oiled silk may be used, and later stimulant applications of mustard or capsicum and water may be added.

Anxious friends and nurses also sit in judgment on your management of stomach and bowels. Ought the swallowed

mucus to be evacuated from the stomach by emetics? Alarming symptoms often arise from gastric intestinal irritation excited by the retained mucus. Castor, as well as other oils, excite the secretion of bronchial as well as intestinal glands, and are consequently unsafe to use when the lungs are already filled with the exudation from the disease; and yet many homœopathic practitioners prescribe castor oil. As the lungs are relieved by the effort of vomiting, this resort may seem necessary to save the patient. If so, the same precautions in the choice of an emetic as a purgative should be exercised. Emetics that excite prolonged nausea cause too much bronchial action. Gastric irritants are safest and surest. We do not speak of these measures to recommend them, for we have never considered them necessary in our own practice.

However, if a Homœopathic physician considers such treatment necessary let him apply it intelligently. It may be to his advantage sometime to know the composition of "rough-on-rats" with its toxicological effects and antidotes.

The physician who uses soothing syrup and other proprietary and secret nostrums can only despise himself; he had better be an intelligent allopath.

To sustain the patient the writer is in the habit of giving small quantities of hot milk frequently. To keep the stomach and bowels in good condition we administer hot water. This can generally be done by putting it into a nursing bottle, by which means a child will often take from four to eight ounces at once.

MARASMUS.

BY WILLIAM DUNN COOPER, M.D., LANSING, MICH.

(Read before the Homœopathic Medical Society of the State of Michigan.)

It is not my intention to discuss diseases of children as found in the infirmaries, hospitals and large cities; but I

shall single out one which the general practitioner usually meets with fear and trembling ; a disease that requires the closest prescribing, and a constant and untiring observation of the action of remedies, as well as the development or cessation of symptoms ; for I believe, gentlemen, that the totality of symptoms not only assists us in the selection of our remedy, but gives the key-note to the surest diagnosis of the pathological condition and its significance.

For the sake of convenience, let us divide the subject into three sections, viz : *Ætiology*, *Pathology* and *Treatment*.

Ætiology : This may be divided into : first, hereditary taint ; second, induced or irritating causes.

Hereditary taint : We are fully aware that pure undefiled nature *never* sent into this world such a conglomerate mass of human corruption ; therefore, gentlemen, we must look for the cause of the condition to the transgression of one or more of God's unalterable laws.

I am fully convinced that the psora of Hahnemann, or a scrofulous diathesis, is the starting point from which this, as well as many other diseases, have their origin. A mighty step in advance will have been taken when our nation allows no marriages except to those holding a certificate from a board of competent medical examiners ; if such a law be not passed and enforced, then we as a nation, within a few centuries, will be reduced to almost total physical inability.

When we meet a case of marasmus, we may by a little observation and inquiry elicit the fact that one or both of the parents are scrofulous—possibly in a latent form—or one or both may be syphilitic, or whatever the special case may be, it can invariably be traced to some hereditary constitutional taint ; therefore, under this division of *ætiology*, we are compelled to accept the condition that already exists, and lay the charge to the parents, where it justly belongs.

We are fully aware that all children born of scrofulous parents do not suffer with marasmus ; but this leads us to our second division of *ætiology*, viz : *Induced or irritating*

causes. Here we must admit that we have the same constitutional tendency, but in a latent form only, waiting some irritating cause to ignite the inflammable mass, which rapidly travels the path to total destruction unless speedily arrested by appropriate treatment and untiring vigilance on the part of both physician and nurse. We may consider as some of the irritating causes, improper food and hygiene, cholera infantum, summer complaint, dysentery, gastralgia or derangement of the digestive apparatus incident to dentition, scarlet fever, measles, whooping-cough, influenza, in fact any thing that will cause a catarrhal condition of the mucous membranes will invariably open the door to this latent condition, which apparently is but awaiting just such an opportunity to show its power and reek its vengeance upon the frame of the poor inoffensive and helpless little creature.

In considering the pathological condition, we must bear in mind that we meet cases of all degrees from the slightest to the most profound lesion of the system. We are here compelled to follow the same division as given under *ætiology*.

Under the first division, the condition at birth may be slight, but is often very profoundly marked; in some cases degeneration seems already to have been far advanced, as is shown by the remarkably wrinkled, withered and shriveled condition; the bones soft, often twisted, bent, broken, dislocated, the epiphyses not united, muscles contracted or paralyzed, catarrhal condition of all the mucous membranes which are thickened, usually of a dirty gray color, especially that of the mouth and rectum, which is covered with an aphthous and ulcerated condition, which in the mouth attacks especially the buccal cavity and the under side of the lower lip, while from the rectum it may spread over the greater portion of the buttocks, inside of the thighs, perineum, and often the external genital organs.

The child is restless, peevish, fretful, crying, as if continually distressed, which is undoubtedly the case, and which

can only be faintly comprehended by those who have suffered with canker sore mouth or an ulcerated rectum. The child will only be comforted when at the breast—which is usually insufficient in quality or quantity, or the bottle; it partakes of enormous quantities of milk, which is rejected as soon as swallowed, or presently after, or if retained by the stomach, is soon passed in an undigested condition from the bowels. As a general rule, the stools are loose, of a grass green color, mixed with lumps of curdled milk, and connected by strings of mucus; there is attending it *a very offensive odor* like carrion or decomposing animal matter. Vomiting may occur at any time and way—watery, or milk as swallowed or curdled, sometimes in large chunks.

There is a peculiar odor about the child which penetrates the whole house; an odor never to be forgotten, but which will lead one familiar with it to a diagnosis even before seeing the child.

It is an easy matter to give our ideas and observations of the pathological condition of these cases, but the most difficult and important part is yet before us. Let us, therefore, turn our attention to the

Treatment.—We can not depend entirely upon remedies in these cases, but must give the closest attention to the hygienic surroundings of our little patient and its mother; therefore for the sake of convenience we will consider the the treatment under two heads, *viz.*: *Hygienic* and *therapeutic*.

Hygienic.—One of the first things our attention is called to is the diet. If this dyscrasia—which has already been spoken of—has been transmitted by the mother, there will usually be found some abnormality in the condition of the breasts; there may be a deficiency of milk either in quantity or quality, or both, or there may be a caking of the breasts—a condition which in my opinion is very injurious to the welfare of the babe, owing to the altered chemical condition of the milk, and which will sooner or later be re-

jected from the stomach of the infant in a thickened and sour mass. When this condition of the breast goes on to suppuration, we not only have the same altered condition of the milk, but in addition to that, a decomposed animal substance, which means sickness if not death to any system into which it is introduced.

One other condition of the breasts I wish to call attention to, and that is found much more frequently with blondes. I speak of a dry, scaly condition, of, and surrounding the nipple: this may be caused by an eruption, but I think as a rule, will be found connected with a general exfoliation of epithelium, especially of those parts of the body which are subjected to more or less friction and moisture, as the nape of neck under the hair, and the inner side of the joints, especially the large joints. Wherever this condition exists and the child is kept at the breast, the physician will have a patient most of the time, and by close observation will find that sooner or later that child's skin will have the same yellow, wrinkled, dry and scaly appearance, which I believe to be but a proving of that exfoliated epithelium, and which is just as marked as our proving of *Psorinum*.

But do not understand me to say that this is the only factor in bringing about that child's condition; but I do say that it greatly aggravates it and ought to receive due attention from the attending physician. I am fully aware that many physicians prefer battling with the above conditions, than take chances with artificial food, but each must choose for himself. We are now asked, what kind of a change is to be made?

Unquestionably human milk is far preferable, an effort should therefore be made to secure a wet-nurse, but as much caution should be exercised in putting a child to the breast of a wet-nurse as to the breast of the mother.

We have no alternative generally but to resort to artificial food, and the practitioner is driven to his wits' end, for a selection from the numerous brands, each one claiming to

be "*the Best*," but I tell you, gentlemen, there is not one in a dozen of them that would not turn the stomach of a healthy man: then what could be expected of its action upon the digestive apparatus of that poor, weak little babe?

Condensed milk is claimed to be superior to cow's milk, as it is brought to a uniform standard, but it will be found that a child fed upon condensed milk will continually weaken and lose flesh, while the daily consumption of milk is something enormous.

Prepared foods should not be employed where the fresh milk from a cow can be had, and that can usually be obtained outside of our large cities. This milk as it comes from the cow, is far better than any prepared food I have ever used; yet cow's milk can be greatly improved,—*i.e.*, the proportions of the constituents brought nearer to that of human milk—by preparing it according to the simple rule given by Guernsey, which is as follows: "This milk should be allowed to stand from two to four hours after being drawn from the cow; then the top part only, being the richest in fatty matter, should be dipped off and diluted with an equal part of pure warm water; the whole to be sweetened by pure white sugar, or sugar of milk." Allow me here to suggest that the physician give personal attention to this, otherwise the milk is often sweetened by brown sugar, which irritates the bowels and weakens the child very much.

The utmost care is requisite in order to keep the nursing bottle and other utensils used in artificial nursing in a perfectly sweet and cleanly condition. The child should be fed at regular intervals and not every time it cries; this also must be insisted upon, otherwise the child learns to cry every time the nipple drops out of its mouth. The mother or nurse, in order to keep the child from crying, will supply themselves with a large bottle, which they fill, then put it in the crib with the baby, the nipple in its mouth; the child stops crying for the time, nurses heartily, then lies there

with the nipple in its mouth and occasionally taking two or three draws at the bottle ; the milk becomes cold and rancid, the stomach over-loaded, colic sets in, diarrhœic stools, child vomits, the attendant cleans up the muss, wipes the nipple and puts it back in the baby's mouth, and it fills up again on the same cold and rancid milk. The doctor is called upon daily to relieve the colic and diarrhœa ; he gives the indicated remedy, which gives but temporary relief, he studies the case, and after trying various remedies without relief, concludes his medicines are not good, or drifts off into Allopathic treatment ; but, gentlemen, that don't save the child ; we must look after the *minutiæ*.

Two nursing outfits should be employed, one being kept immersed in soda water or salicylic acid solution, while the other is in use, always being careful that they are thoroughly rinsed before using. I would recommend a double bottle in order to keep the milk at the right temperature, as milk, even in small quantities, will become cool before it is all nursed. While milk ought to be the only article of diet for young infants, yet as they get older this may be prepared in various ways, which not only makes it palatable but often increases its nutritive value.

Another article of food has proved of great value in my practice, especially for children over nine months of age ; I speak of "Beef-a-la-mode," This is prepared by putting chipped dried beef into a stew-pan and covering beef with a pint of water, then kept just below a boiling point for about twenty minutes ; the beef is then removed ; the gravy should now be brought to a boiling point and thickened with flour, adding a small amount of butter. This is not only a nutritious food but seems to have a soothing effect upon the irritated bowels and stomach, as is shown by a more natural stool and less vomiting.

Before closing this division of the subject, I want to call attention to the necessity of having plenty of fresh air and especially out-door exercise, in company with a congenial nurse.

Therapeutic Treatment.—We are fully agreed that the selection of our remedy should be by the totality of symptoms, therefore it would be useless for me to mention remedies according to the pathological condition.

Perhaps some would like to know what remedies are most likely to be indicated. I will mention abrot, aethus, aloes, alumina, ant. cr., apis, arg. nit., ars., baryta carb., benz. ac., borax, cal. carb., cal. phos., carb. veg., cham., cinch. off., graph., hepar., iodine, kali. hydr., lycop., mag. carb., mer., nit. ac., nux vom., phos., phos. ac., pod., psor., puls., rheum., spig., sulph., therid., verat. alb.

While I wish to avoid discussion on the subject of attenuation, yet, I feel it my duty in connection with this paper to give my observation in these cases. Having used remedies ranging from the tincture to the 200th, I am compelled to admit that the most beneficial results have been from the higher attenuations, they giving more prompt and lasting results.

Before closing I will give some clinical cases in verification of the divisions given under ætiology.

Case 1st : Showing hereditary taint.—Parents were cousins and both of a scrofulous diathesis.

Although this case was about four years of age when it came under my observation, yet the preceding history was found to be in accordance with the condition then presented. At this time the child was unable to stand without support, extremities atrophied and weak, especially the extensor muscles, general atrophy or wasting of the body, mind cloudy, fretful at times, understood when spoken to, but unable to speak, only to make an unintelligible noise, ptosis of upper eyelids, listless dull eyes, face cadaverous in appearance, mouth usually open, with profuse dribbling, mucous membrane of mouth of a bright pink color, often covered with aphthæ, tonsils very much enlarged, appetite poor, lived mostly on milk and cookies, frequent vomiting, often of large chunks of milk, bowels generally bloated,

stools irregular, diarrhœac, and even dysenteric on any change of diet, from excitement or unusual exertion, especially during hot weather, stools usually green, slimy, covered with mucus or blood, or like intestinal scrapings, generally painful, very obstinate to treatment, seemingly the least thing would start it anew, urine profuse and often passed involuntarily, sweat profusely on least exertion, cadaverous smell about the child most of the time.

To sum all up would be to say that it was one of the most loathsome objects that it has been my lot to meet.

Treatment.—Its diet was gradually increased to nourishing food suitable to its age and condition, changed from the house to outdoor exercise and encouraged to play in the dirt. The principal remedies applied were: Aethus, baryta carb., cal., carbo. veg., cham., spig., psor., according to indications.

The case gradually improved and in the course of two years was able to walk fairly strong, and talk enough to make its wants known, bowels gained tensity, tonsils diminished, dribbling stopped, and the cadaverous look passed away to a great extent, yet there remained and probably always will, that blight caused by parental folly.

Case 2nd.—Child presented dorsum, delivered by turning, absence of bones in head, all bones of the body soft, forearms and legs twisted, bent nearly at right angles, many of the epiphyses not united, skin yellow, wrinkled and dry, catarrhal condition of eyes, nose, head and bowels.

Mother unable to nurse babe on account of typhoid condition coming on in about two weeks after confinement, was put on bottle with condensed milk until suitable cow's milk could be found, bowels very bad, usually grass green and slimy, aphthous condition of mouth and rectum. Soon procured cow's milk, which agreed much better, was able to control condition, using principally, Abrot., acon., cham., calc., mag. carb., mer., psor. In a few weeks child was considered well enough to be from under constant care, but in

about two months the child died, not having further treatment.

On looking up the case we found that the milk had been sweetened with sugar of any kind that came to hand first, milk put into a large bottle to save work. It is scarcely necessary to say that the child gradually pined away and died without the family realizing it was sick.

Let us consider a case under division 2d, or "Induced causes."

Case 3. Child born plump, strong, healthy boy, well developed in every way; perfectly healthy and well until about six months of age, when it had an attack of cholera infantum; treated by a "Regular"; was sick four months when it came into my hands. On stepping into the house the first thing I noticed was that characteristic cadaverous odor, which enabled me—even before seeing the child—to make a diagnosis of the case, but not a prescription. So I went to work; found the looks of the patient to correspond to the odor: profuse sweat, especially about the head, no teeth, very much emaciated and a countenance expressive of suffering, fretful and peevish; during a movement of the bowels, it would draw its lower extremities up, laugh and crow, evidently enjoying a momentary relief from pain. Stools, cadaverous smell, thin like dirty water, passing through diaper and wetting the bed; passages more frequent after midnight until 7 A. M. Stools sometimes grass green, at which times there was evidence of pain. Urine profuse and odor greatly intensified.

Was being fed on condensed milk, of which it was taking enormous quantities, at least a nursing bottle full every hour.

The treatment of this case was in every way satisfactory. Remedies employed were: Benzoin, borax, abrot., calc., pod., psor.

It is hardly necessary to say that the condensed milk was changed for cow's milk, quantity regulated, strict attention

given to care of nursing apparatus. Beef a-la-mode, milk gravy, and sometimes a little boiled potatoes, mashed very fine and warmed over in milk, with a little salt, no pepper, was given. Outdoor exercise insisted upon.

In three months from commencement of treatment we had the satisfaction of seeing the child fat and round, able to walk alone and plenty of teeth, apparently in perfect health, which has continued ever since.

POST-PARTUM HÆMORRHAGE DURING, OR SHORTLY AFTER, THE THIRD STAGE OF LABOR.*

BY H. TYLER WILCOX, M. D., ST. LOUIS.

It occurs more often in higher civilized life. Why? Because surroundings of this class are lax habit of body which engenders uterine inertia, and lack of proper exercise, tight clothing, etc.

Over distension of uterus by multiple pregnancy, and over growth of child, or placenta, may exhaust the muscles and thus no power to contract remains. Nature provided for this power, but art in fashionable life has abused it. I do not know of any data of the frequency of post-partum hæmorrhage to that of normal births. The hæmorrhage may arise from a lacerated cervix, exposed orifices of uterine blood-vessels and capillaries, from separation of placenta and non-contraction of the uterus, causes, *not* from fullness of the arterial system, perhaps a portion of the placenta has been retained and undetached, which prevents contraction of the uterine muscles and nerves. Some women have a hæmorrhagic diathesis.

No branch of obstetrics calls for so much skill and courage on the part of the accoucheur as parturient hæmorrhage. To be composed and firm, yet dexterous, with

*Read before the Missouri Institute of Homœopathy at St. Louis, April 27, 1887.

knowledge to act, are the elements of success, and without these requisites no man or woman should assume the responsibility in this domain of medicine; for, ignorance of the course to pursue will be death to the patient. Yet how often is it given over to unskilled hands, and valuable lives sacrificed that might have been saved. Who shall count the tear-stained paths which many have trodden through the ignorance and incompetence of professed accoucheurs? None but the All-seeing Eye, for the grave too often covers the sin of their ignorance.

Treatment.—If from retained placenta, slowly draw on the cord with one hand, the other on the fundus; gentle kneading aids contraction, not too severe, lest inversion of uterus occur. If undetached, introduce the hand with care and detach—compression of aorta advised by Meigs and Baudelocque—to check downward rush of blood. If hæmorrhage is internal, known by sudden pallor, hiccough, gasping for air, etc., then excite contraction by stimulants, ergot and quinine; these are aids to overcome inertia. After removal of placenta, cold applications, and hot too, vinegar, internal and external, chloride of iron, zinc, cinnamon, sabina (Whew! what a combination!) alum, gossypium. A styptic gives vessels time to clot at orifices and helps to tide over until contraction, sufficiently energetic to overcome the hæmorrhage set in. Electricity is another powerful agent, and here I believe the profession is to find its great stronghold. It stimulates contraction and nerve force and aids the action of remedies, and relieves ruptured blood vessels from blood pressure. Elevate the hips, put child to the breast to stimulate contraction, if not too much exhausted. Pour cold water from a height over epigastrium, plug vagina; hamamelis, internal and external. In a recent discussion in the Baltimore Medical Society, “the exploration of uterine cavity in hæmorrhage, post-partum, is decided a necessary procedure, deeming the risk of retained placenta greater than that of correcting, thereby running risk of septicæmia

too"—but, as the authors say, the *only* safe way is "to find a correct diagnosis and as soon as possible." I would like to hear from others on this point. I have not the courage to decide for it without further statistics of success. Gynæcologists have much to be thankful for in the progress made the last few years in instruments of research in the uterine cavity, and the antiseptic remedies to aid in such investigation. Science and art now afford many means for producing thrombosis of uterine vessels. A preventive treatment of hæmorrhage of inertia is never to leave the hand off the fundus after child is born, and gentle kneading; a point never to be lost sight of. Trousseau says that "inhalation of oxygen has recalled to life women regarded as lost from uterine hæmorrhage and exhaustion." In this progressive age we want to consider this. I use it with great success in debility and nervous exhaustion, but have not tried it in uterine hæmorrhage. Some argue that the use of chloroform predisposes to hæmorrhage. It has not thus served me, because given with great precaution perhaps. The great desideratum is consciousness of ability to act.

INSUFFLATION OF THE CERVIX UTERI.

BY PHILIP PORTER, M. D., DETROIT.

In the topical application of remedies to the eroded cervix we meet with several objectionable features, which, while they do not positively hurt the patient, produce discomfort that can be avoided by the above method of introducing the powdered drug, when it is desired, to the proper location. The ordinary means of treating cervical diseases, by the "glycerine" preparations, often leaves an unpleasant and disagreeable "wet dribbling," that proves uncomfortable to the lady, which may be avoided by a little practice and a properly constructed instrument.

The "capsule method" of introducing powder has several disadvantages, one being the pressure of a hard substance against a tender and sensitive organ, while the capsule is melting down, producing pain, and the second, the "slipping out" objection. The manner of applying the powdered drug enters largely into the comfort and success of the treatment. The old or ordinary way of introducing the various powders into the genital canal; its liability of spilling out from the blades of the speculum upon the patient's clothing (like iodoform, hydrastin or tannic acid); the awkwardness on the part of some operators; all afford objections which can be overcome by employing an insufflator like Clay's or Leffert's.

The writer is having an instrument constructed which will be an improvement over these and one that will encourage many to adopt this method of treatment in preference to the old, of treating the cervix and the uterine cavity with remedies that are carried through such vehicles as glycerine, to a diseased mucous membrane, when the said vehicle is known to have such a decided chemical affinity for water in the tissues, that the membrane is really converted into a discharging rather than an absorbing surface; the application being practically washed away, escaping on the napkin or clothing. Too true is the fact, that but few drugs are absorbed, locally, to the extent supposed, when applied to an eroded cervix, except in the form of powder. Even then, which shall we honestly, give the credit of relieving: to our own blind egotism, coupled with ignorance, or to the moral effect the local treatment may have upon a susceptible or morbid mind of the patient? We have also seen practitioners treat the cervix (?) by introducing the fore-finger, lubricated with medicated vaseline. Shades of Esculapius! shall we call this kind of work gynæcological practice? How much of the original mixture ever reached the cervix?

In all local treatment, there is a disposition to employ

our remedies too powerful. We have witnessed intense and serious pruritus and eczema of the vulva and surrounding external parts, produced by the dribbling of the application which found there a resting-place in its escape from the vagina. By a little ingenuity on the part of the patient and physician, the desired quantity of the powdered drug may be placed in tissue paper and carried up to the cervix, through an ordinary Ferguson's speculum, and permitted to remain until set free by the bursting of the wrapper, as soon as the paper becomes moistened by the secretions. While on the subject of powder, or "dry" applications to the cervix, we would also refer to what is known as the "Torpedo Method," or the "*Torpedo Vaginæ*" application. The originator is unknown to us. Although the torpedo method does not soil the clothing, but from its peculiar formation, not unlike a Fourth-of-July torpedo, it at once spends its entire force upon the vaginal tissue, especially, the vault of the vagina, thus missing its prime object, *i.e.*, an application to the cervix. We have, in cases where it was deemed advisable, ordered six to ten grains of the desired powder put up in ordinary "commercial tissue paper," cut into square pieces of four inches, placing the powder in the center of the paper, bringing the four corners together, giving them a twist, as with a "torpedo," and you have a very complete preparation for an abraded cervix. With a Ferguson glass speculum almost any one can apply one of these "papers" of powder. We employ, in the third trit more kali bich.: merc. sol.: arg. nit.: nat. mur. O. I employ the crude salt, potass. permanganate 2 X: (this is a difficult preparation to keep, requiring a black, painted, or protected otherwise, bottle, and well corked); atropine 3rd: prussic acid 1 X: permanganate of Zinc 1 X: Boracic Acid 1 X, and any other remedy, not forgetting merc. cor. 3 X, to the 6 X, *that may be indicated*.

The *modus operandi* of supplying insufflation to the cervix is, first, to expose the organ, employing for this purpose, a

perineal retractor, Sims' or some other, or the ordinary bivalves. Then, second, thoroughly removing all secretion from the cervix; using a strong solution of *acetum* (vinegar) to coagulate the albuminous discharge, if it proves tenacious or troublesome. If there be any hæmorrhage following this treatment apply the vinegar as it has decided refrigerant effect and will soon control any local flow of blood. Third, after the exposed parts have been prepared, the selected powder may be thrown in upon the cervix with the insufflator and a dressing of dry cotton or prepared wool so placed that when the speculum is withdrawn the uterus will rest upon it.

In the use of the speculum we should not lose sight of this important fact : that in almost every case the employment of any instrument except the retractor, to expose the cervix, the organ must be displaced to bring it within the operator's view. Examine the normal anatomical relations between the uterus and vagina and you will readily comprehend what a serious effect this treatment will have upon a set of weak and inflamed (chronic) ligaments if continued twice a week for a year or more. We regard the employment of a bivalve or Ferguson speculum, with the patent dorsal position, and the practice of drawing down into view with a tenaculum, the uterus, a pernicious one indeed.

EDITORIAL.

ERGOT IN OBSTETRICS, IN THE UNITED STATES.—Ergot has always furnished an interesting text for study to our American practitioners. The book review of Vol. III. of Charpentier's works touches briefly upon this drug, citing some rules observed by European teachers and presenting excellent food for thought for our physicians.

We venture the remark that our own school prescribe it now oftener from indications furnished by the physiological action of the drug than by the law of *similars*. Our older obstetricians are more

prone not to accept and follow the teaching of Schroeder and Charpentier. For years they have been in the habit of prescribing ergot at all times and have been able to demonstrate that they have done harm. We have met old practitioners who cite their experience claiming never to have had a single case whereby they could trace an accident or bad result to the hasty and ill-timed administration of ergot. Do they stop to consider that not to-day, nor in one year, nor even in some cases in ten years can they positively state that it was not through the deleterious action of ergot that a patient is now seeking relief at the hands of a gynæcologist! Have they considered that the woman, who is having a lacerated cervix fifteen, yes twenty years after, repaired, was the victim of ergot given with an unsparing hand in some tedious case of labor? We often meet practitioners who have grown old and gray in an honorable practice of a quarter of a century, who make the statement "in an extensive obstetric practice I never have had a case of lacerated perineum or cervix." Could I but inform that physician that no longer than one month past we performed coloperineorrhaphy where there had been for nearly twenty years, almost complete procidentia uteri, as the result of a too large a dose of ergot as the lady stated—which not only lacerated the poor woman but killed the child. Many times, we have by carefully questioning the patient ascertained beyond a doubt, that the laceration or a prolapsus of the posterior or anterior walls of the vagina was the result of the administration of ergot. The patient will state, being given a little time to collect her thoughts "I do remember, the doctor said he would give me something to hurry up my pains and it was a fearful dose of a nasty tasting medicine which soon brought on fearful pains and I was soon over." Can any of our readers duplicate the picture?

We can imagine where there might exist a condition which would justify the administration of ergot. But to save the personal time of a practitioner, the habit is fearful, as is now demonstrated to the gynæcologist, every day. We earnestly believe that the drug has been a greater enemy to womankind than a benefactor. The late Dr. Albert N. Smith, of Philadelphia, thus expresses himself, "I do not believe that it is ever needed under any circumstances but that it is always capable of doing harm, and generally does do harm."

MISTLETOE—VISCUM ALBUM. Apropos of Ergot, we have now a remedy that to a certain extent will take the place of ergot, or, more properly speaking, assign this much abused drug, to its proper sphere. Mistletoe is now enjoying the attention of our school and under our management is being "proved." After a careful investigation we shall make our report. The preparation is known as the Fluid Extract Mistletoe—(*Phoradendron flavescens*. Nutt.) synonyms—American mistletoe. *Viscum flavescuro*. Pursh. Part employed the leaves, natural order—loranthacæ. Habitat—Southern states. Properties—narcotic, antispasmodic, and tonic, has been found beneficial in epilepsy, insanity, paralysis and other nervous disorders. (King), "As compared with ergot, he says (1), it acts more promptly and surely : (2) it produces intermittent contractions, instead of tonic—hence, may be used in any stage of labor, or in primiparæ, when ergot is not advisable : (3) it can always be obtained fresh and does not deteriorate by keeping." (Dr. Long). Dose (allopathic) "fifteen to sixty drops in labor, repeated every twenty minutes."

Mistletoe is a parasitic evergreen shrub which grows upon a great variety of trees, and extends from Sweden to the Mediterranean, and is also common in the southern and western countries of England. The American plant of mistletoe is, so far as we have been able to determine, the same in its action, as its foreign relative. Dr. E. M. Hale has given some attention to this drug and we believe was the first to introduce it. We hope to add to his report by the time we are through with our provers, (7 ladies—3 married).

Already some important facts have been gleaned regarding the physiological action of mistletoe, and although associated with legends and superstitions ; held in high veneration by the ancient Britons ; used as Christmas decorations ; it had not been thought of in connection with medicine.

Mistletoe has been employed to produce uterine contractions in delayed cases of labor, and, to the surprise of the prescriber, the pains were intermittent instead of persistent, as in ergot. Its action on the ovaries, especially the left, is to relieve dull heavy sagging pain. In one case of a young married lady, five months pregnant, who complained of a dull heavy distress in her left

ovarian region immediately after coition, mistletoe, five drop doses, relieved in a short time. In one other clinical case of the same nature, pain in ovarian region after coition, a prostitute, mistletoe cured in two weeks. We shall look for its affinity for erectile tissue in our provers. We have already demonstrated beyond doubt its physiological effect on uterine fibers, as it is a uterine excitant. Unlike ergot, it does not depend upon the influence of gestation or of the presence within the uterine cavity of any foreign substance to develop its peculiar action. It is a well known fact that the uterus responds better to the action of ergot when its fibers are hypertrophied through pregnancy, as the drug performs its best results when the womb is at full term and the shorter the period of gestation the less the uterus responds to the action of ergot. With mistletoe it is different, the pregnant state having no influence over its action.

We hope some of our practitioners living in the South will make a tincture, according to our own pharmaceutics, and prove the drug. The rule for preparing the plant, that is—the fresh berries and leaves, is to make a pulp, by chopping and pounding the leaves and berries and then weigh. Take two parts by weight of alcohol, the pulp mixed thoroughly with one sixth part of it, and the rest of the alcohol added. After having stirred the whole, pour it into a well-stoppered red bottle, and let stand eight days in dark cool place. The tincture is then separated by decanting straining and filtering.

THE TENDENCY OF THE MEDICAL LITERARY WORLD.—The study of the progress or of the regress of the human mind in connection with its influence over uniformity of methods leads toward the conviction that individuality is rapidly disappearing. Nor is this less plainly to be seen in watching the tendency of the medical world than in other directions. Not that we mean to say individuality has deteriorated, but that those unhappy tendencies, leading to error, inevitably following when the nîsus of a medical epoch may be summed up in the thoughts of one great man, are now combatted by that interchange of ideas brought about by co-operation. One man no longer stands head and shoulders above the rest, because of the wide dissemination of investigation,

of analyses, of reasoning from cause to effect and of experience, has created so many who are equal in medical knowledge. Thus it is not the degeneration of one, but the advancement of many; a gradual evolution and adjustment of individuals to a position where supremacy is no longer a desideratum.

As evidence, witness the growth of associated work in authorship: "Holmes' System of Surgery," "The International Encyclopædia of Surgery," "Pepper's System of Medicine," "Arndt's System of Medicine," "The American System of Gynæcology" (in press), and the various foreign encyclopædias are all produced by the co-operation of men equally eminent in the medical world. Such, then, is the tendency. The individual is of less importance than formerly, but the progress of medicine is markedly benefited, for we must put ourselves in connection with co-laborers, and in our abstractions from the concrete and the conversion of an abstraction into an entity, co-operative observation will be found the only method adequate to future construction.

EDITOR'S TABLE.

—We are enabled to announce the appearance in our next issue of a review of a text book on Diseases of the Eye, by Dr. Edouard Meyer of Paris, authorized translation by Freeland Fergus, M. B. In view of the fact that so many times ocular disorders depend upon reflex relationships, it is important, at least, to be able to recognize causal affinities when they depend upon lesions of the female genitalia. Thus it is that, to us, a perusal of a book of this character, containing the latest French researches, is of the greatest interest, for these lessons of bodily correlations even in the humblest degree can not fail to teach that every organic change, visible or invisible, sensible or insensible, does not pass away wholly within a domain of narrow environment but has its due effect upon the body whole.

—Owing to the numerous complaints that have reached us relating to "notices" of various kinds being omitted from our pages, the editor wishes again to call the attention of the subscribers and contributors to the fact that we neither have the space, nor is it proper for us as a special publication, to publish matter, however interesting, that is general in its character and information.

We should be happy as editor to exchange courtesies as they present themselves from time to time, but our field of labor, as

announced by our title page, places us in a restricted sphere of medical literature by which we must abide. While we could find any amount of interesting matter to "notice," as a medical journal, having selected our special departments to represent in medical literature we shall confine ourselves to such subjects as have some relation or bearing upon either obstetrics, gynæcology or pædology leaving to the general medical journal general medical news.

—Under the title of "Miller on Diphtheritis" we give the following comment, as taken from an allopathic pen and an allopathic journal, *The St. Louis Med. Journal*, on "homœopathic findings in diphtheritis."

"This school of medicine numbers among its practitioners, some of the finest, educated minds, found in any school of medicine on this continent, or in Europe. Its literature as a consequence, manifests a large amount of scientific investigation, careful analysis, and patient, careful consideration.

"The most rigid advocate of ponderous doses, can no longer frown infinitesimal triturations out of existence; neither does 'infinitesimal-ism,' constitute any essential part of Homœopathy. Their law of cure is independent of "dose." It simply expresses relation, *quantity*, is a matter for individual judgment. The present tendency of the medical world is towards the minimum dose, and if Homœopathy in order to first reach the goal, has gone to the extreme; it is only the reaction of the opposite, heroic treatment, which might have been expected, as an inevitable result. This practice has now stood the test of years: experience has demonstrated its practical utility, an interested, intelligent public demand its therapeutics, and demand it because satisfied with its results, demand it in preference to older methods, hence, older methods can complain as they please, while success attends the Homœopathic practitioner, the public will demand his service independent of methods.

"The hue and cry about '*Infinitesimal Triturations*,' raised against Homœopathy, as though this was all there was in it, is not only ungenerous, but is meanly unjust. According to their law of cure, if it required a cart-load of any remedial agent to develop its "*similia*," he is at perfect liberty to give it. But if the cart-load is unnecessary, and the thirtieth, or five hundredth, or five thousandth part of a grain will cure the disease, it is certainly more humane, more in keeping with christian kindness and common sense, to give the smallest amount that will do its work, and allow the cart-load to pass along."

ORIGINAL TRANSLATIONS.

A NEW TREATMENT OF CHRONIC METRITIS AND IN PARTICULAR OF ENDOMETRITIS BY THE INTRA-UTERINE CHEMICAL GALVANO-CAUTERY.

We take this manner of acknowledging the receipt of a thesis, "Sur un nouveau traitement de la métrite chronique et en particulier de L'Endometrite par la galvano-caustique chimique intra-utérine," presented to the editor with the compliments of the author. Dr. G. Apostoli of Paris.

Dr. Apostoli has accomplished much in electrotherapy and has introduced several new as well as interesting methods of treatment in the applications of electricity to diseases of the female sexual organs.

In substituting the use of the chemical galvano-cautery for simple Faradization, he has greatly extended the line of thought indicated by his friend and master Dr. A. Tripier, when in August 1859, he (Tripier) addressed his first memoir to the Academy of Sciences of Paris, on the use of "Faradization in the treatment of engorgements, of increased growth, and of deviation of the uterus and of membranous hyperplasias of the contractile organs," and in his "Lecons cliniques sur les maladies des femmes (Thérapeutique générale et application de l'électricité à ces maladies)" Paris, 1883.

The present article from Dr. Apostoli represents the full development of a memoir communicated to the French Association for the advancement of the Sciences, Congress of Nancy. With the assistance of our translation and the labor of Dr. H. H. Crippe, the prominent ideas are here brought forward.

In introducing the subject the author speaks of the preponderant influence which circulatory troubles exercise over the nutrition of the contractile organs and how, in tracing this, one may often put the finger upon the different processes of the pathological history of perverted local circulation and bring into play as an excitant of the smooth muscular fibre, electricity in a "dosable, localizable and submissive form."

He thinks that we cannot ignore to-day, that the great majority of uterine inflammations arise most frequently from the arrest of retrograde metamorphoses of the uterus after labor or abortion; being created wholly through changes of uterine subinvolution and those circulatory troubles characterized by congestions and states presiding over their initial evolution. Thus it is that Dr. Apostoli recommends the use of electricity as preventive after labor as follow: "If then the physician interferes in removing obstructions and with simultaneous antiseptis, in producing a pas-

sing hyperæmia, a kind of circulatory drainage if he combats the primary inertia of this organ, of which the circulatory slowness predisposes to all the subsequent inflammations, it will make an excellent therapeutic application which acts at once as a preventive and a curative. Such is the rôle of Faradization, which applied in the uterus in a proper way, preceded and followed by antiseptic injection, constitutes the true interstitial massage, provocative of contraction of all the unstripped muscular fibres, exciting and hastening the circulation, accelerating the absorptions of the exudation and correcting also a languid and perverted nutrition."

Concerning this use of Faradization following labor, Dr. Apostoli, in a communication to the Academy of Medicine (Paris, 1881) entitled "Sur une nouvelle application de l'électricité après les accouchements," has already given a summary of his conclusions. These are here reproduced with additions made at this date.

1. "Faradization of the uterus although more or less painful is always absolutely inoffensive and it is never followed by any inflammatory reaction.

2. "Faradization is generally followed by a manifest sedation, which succeeds the séance.

3. "Faradization considerably abridges the convalescence, and accelerates the involution of the shrinkage of the uterus, which one can no longer perceive above the pubes, through deep palpation, from the eighth to the tenth day in general.

4. "Faradization accelerates the return and the exercise of all the functions.

5. "Faradization preserves, in general, the female from all of the uterine complications, which are the effects of parturition.

6. "Faradization ought to constitute an excellent treatment, preventive of uterine deviations, as retroversion or retroflexion, those sequelæ of labor, so often provoked by the dorsal decubitus.

7. "Faradization appears to diminish the total duration of the lochial discharge.

8. "Being given the same dose of Faradization the contractibility of the womb is very variable and is opposed to uterine inertia.

9. "The action of Faradization upon the uterus compared to that of ergot is manifestly more prompt and more energetic.

"In resuming I conclude that uterine Faradization, well applied after labor is a wonderful method, through its simple application, its easy dosage, its rapid and its energetic action which one can interrupt and renew at will.

"I have employed this uniform procedure in an aim, constantly effected, of immediate and of delayed utility; immediate, in order to accelerate the uterine involution, diminish the convalescence and restore the woman with the utmost promptitude, being repeat-

ed with benefit in this direction ; in an indirect aim, preventing even uterine complications, and elevating it to the height of a prophylactic role only in juxtaposition to metritis or subsequent engorgements, constituting thus a most convincing theory, that it is often preventive of the most frequent causes of sterility. * *

* * * * * Is it true that all women have need of the therapeutics I advise ? No, certainly not, and every female who is confined or suffers miscarriage is not fatally condemned to have ulteriorly an affection of the uterus; but their number is unfortunately so considerable and it is so difficult for us to foresee the the uterine future which is reserved to a female who is active, that it makes, as I have formulated, sometimes a therapeutic curative and very often a preventive."

Leaving preventive medication the author presents the subject of chronic metritis. "But suppose, that which is the case in ordinary gynæcological practice, the malady to be constituted by a process more or less ancient, and one which has developed quietly ; three cases can there be presented in particular.

1. "The process begins most ordinarily through the mucous membrane which may be simply hypertrophic or well studded with granulations, with fungosities, or with vegetations ; embryonic elements of new formation appear also in the parenchyma and acquire a considerable importance to the detriment of the muscular stroma whose functions are more or less annihilated. Soon the embryonic elements degenerate and are eliminated *en masse* leaving an exposed surface producing a muco-purulent discharge, more or less abundant.

"On the contrary, frequent hemorrhages attest the presence of fungosities, almost wholly composed of vessels of new formation.

"Soon also the hypertrophy of the dilated glands produces a characteristic mucous discharge.

"We find these three forms, derived from the same source in the presence of internal metritis also called endometritis or mucous metritis, acute or chronic, characterized, as we have seen, by the variable lesions of the mucous membrane, which can coexist in the same uterus, and by a consecutive parenchymatous hypertrophy, due to the formation of a true embryonic stroma, constituted by collections of small round cells disseminated throughout the muscular fasciculi.

2. "In the second case, uterine inflammation is still young, more or less near in its beginning ; it is characterized by an inflammation, more or less atrophy of the mucous membrane and by a preponderant process of congestion or infiltration of the parenchyma, with a circumvascular membranous hyperplasias more or less considerable, which impedes or arrests by its situation the

return of circulation ; we have then to do with a parenchymatous metritis in the first period.

3. "Finally, in the third place, the inflammation is older and the pathological processes more advanced ; that which characterizes it being the resistance and the hardness of the uterine parenchyma, which reminds one of cicatricial tissue, with a circulation *nil* or much obstructed in some situations ; The membranous tissue, young and succulent, becomes then hard and fibrillar and the uterus is pale, indurated, and anæmic ; this is chronic metritis arrived at the second period or the period of induration.

"What can we do against these three various pathological states, which most often do not constitute different pathological entities, and only present themselves to us as a hierarchie of denutritive retrograde process ; the first step of which is subinvolution, simple and recent, and the last, either chronic indurated metritis, or fungous or hemorrhagic metritis.

"A. Tripier who, in gynæcology, considers only one single inflammatory process, engorgement, praises a single uniform medication, that which, as we have seen, is a true triumph as far as preventive treatment ; Faradization. Now here begins his error : the induced current, sovereign, on the day following a labor or an abortion, in new or congestive forms of engorgement or of metritis, begins to loose its claim in the other forms, hyperplastic, regressive, or suppurative inflammations of the uterus, and here the clinique is in perfect harmony with pathological anatomy, showing us that when the uterus begins to be invaded by vessels and tissues almost wholly formed by embryonic elements as in mucous metritis or endometritis—or when the muscular stroma, atrophies and disappears as in the parenchymatous form in its second period, then, I say direct exciters of the smooth fibres, devoid of all chemical actions, find no more a sufficient substratum for their activity ; here, too, A. Tripier has been wrong not to see that ergot, which is nothing but a Faradiseur, general but uncertain, causing contraction of the arteries, similar to the interrupted or induced current, should fail of the preponderance which it had to him in other circumstances where it was judiciously assigned." Dr. Apostoli believes that "the intra-uterine tendency of contemporary gynæcological therapeutics constitutes a true and important progress, which shall bear all its fruits only when it shall be sufficiently systematized, to shelter it from all danger and to subject it to the vigorous control of an exact dosage" and when so developed as to provide against the objections which he formulates. These have been given as follows.

1. "It is brutal, blind and may be dangerous in inexperienced hands.

2. "It lacks dosage.
3. "It is difficult of localization.
4. "It is an action, more less instantaneous, which dies out in general after its application.
5. "It is sometimes sterile, inefficable, or ephemeral.
6. "It treats the mucous membrane and lacks direct action on the parenchyma."

For more than four years, during experiments in the treatment of uterine fibromata by the chemical galvano-caustic, the author has endeavored to apply the same agent to the treatment of chronic metritis and to combat these objections. He now summarizes this formula: "Apply to the uterus the current of a battery at a constant state, in a dose sufficient to destroy the mucous membrane and produce a salutary derivation."

Concerning the necessity of a proper *armamentarium* Dr. Apostoli says: "In order to rightly conduct the new operation which I propose, there should be previously provided good electric implements, of which it is very essential to know the function and the necessary qualities. It must not be ignored in fact that electricity has undergone those changes common to all the good things that are not yet generally understood, and which have been the object of extreme obstruction or of thoughtless abandonment, following their use by inexperienced operators.

It has been thus with hydrotherapy and will still be the same of all the natural forces; blind and brutal by themselves, but demanding, in order to be made docile and thoroughly beneficent, only to be conveyed and confined within the proper limits by the aid of a convenient medium. Our century has had the good fortune to assist in the chemical genesis of the electric flow which we create voluntarily and confine at will within the narrow limits of a flask, however little it may be. It has also been condensed and put in jars, also in a recipient which has taken the name of pile; in this way it has been imported to sell like a fluid material, in requisite quantity, especially measurable; and still more important have we been able to circumscribe its effects, to limit its action, to localize its influence and to cause it to react on such and such an organ of the economy. This is the triumph of these last years, which succeeds a period of deplorable therapeutic empiricism, not yet ceased to reign in the therapeutic applications of electricity. * * * * *. Why the therapeutic caprice, why the vague and often contradictory responses in the employment of a natural force which should not know how to lie? The response is easily given and in a word explains this question so long discussed the lack of dosage, and the ignorance of the physical effects of electricity lead to a vague uncertain and often contradictory therapeutics.

(To be Continued.)

BOOK REVIEWS.

A PRACTICAL TREATISE ON OBSTETRICS VOL. II. The Pathology of Pregnancy, BY A. CHARPENTIER, M. D. Paris. Illustrated with lithographic plates and wood engravings. The publisher also announces that this vol. is Vol. II. of the "CYCLOPEDIA OF OBSTETRICS AND GYNÆCOLOGY." (12 volumes in complete set) 1887. WILLIAM WOOD & Co.

The subject of Obstetrics continued in this volume first takes up in most minute detail all modifications of disease as occurring during pregnancy. The lesions treated of range from mere functional disorders dependent upon slight disturbances of cell relationships, to the most profound disorganizations. This portion of the subject has been presented, of necessity in two aspects, first those "diseases affecting the pregnant woman, independent of the gravid state," and second, "those important and profound modifications which in their turn cause functional disturbances, that find expression in a series of morbid conditions, constituting, properly speaking, the diseases of the pregnant woman." We mark one omission from among these disorders. The writer fails to note those resulting abrasions or erosions of the mucous membrane of the rectum which may prove disastrous either through reflex irritation or by presenting absorbent surfaces.

Among the important points the author notes in speaking of pathogenesis is the relation of diathesis to predisposing causes as modifying materially the course of disease.

The section on albuminuria leaves but one thing to be added, namely, that we regret the inability on the part of most obstetricians to take advantage of those accompanying symptoms of kidney disease so often to be traced in the fundus oculi.

In the classification of states of mental alienation consequent upon pregnancy the old term puerperal mania is much to be regretted as leaving a stamp of inexactness upon our literature. It cannot be considered classical to arrange the nomenclature of mental diseases upon a basis of causation. In the way of statistics the subject of intellectual aberration presented here contains more than any other work extant.

In following the author through the remaining chapters of volume II, there is always a completeness in the manner of presenting the subjects that almost defies criticism. The treatment of "miscarriage" is somewhat instructive and yet that part upon which the author emphasizes his advice is now regarded by our school as obsolete; the "general bleeding from the arm" aside from the old worn-out drugs recommended such as iron, quinine, large doses of opium, choral hydrate etc., there are many sugges-

tions, by way of prophylactics, that are well worth reading. The author touches ergot carefully and in fact that school (allopathic) now begin to accept our teachings that this useful drug has a double action and in the quantity employed by the old school practitioners is as liable to create mischief as to bring about curative results. The "tamponnade treatment" is presented in an intelligent manner; the writer illustrating how absurd is the theory of the effect of an improperly adjusted tampon. Instrumental interference is also presented in an acceptable manner, the author, however, charging to American gynæcologists and obstetricians methods that we abandoned years ago; that is the employment of sharp edged curettes. If there is any radical change our physicians have insisted upon more than the use of the dull curette we have failed to have seen it. The perineal retractor (Sims' speculum) and a painless manipulation with the dull curette for the removal of the retained placenta or shreds of the ovum was first insisted upon by an American physician and has been strictly adhered to when practicable.

Volume III. The use of ergot.—Any consideration of this valuable drug, ergot, whether from physiological dynamo-mechanical view or the dynamic theory, at once arrests attention and becomes interesting. There is no remedy employed in the obstetrical or gynæcological practice which has been misused and abused more than ergot. After an exhaustive consideration of "maternal dystocia," as an abnormal condition of the expulsive forces which may be exaggerated, diminished, or perverted. The causes which emanate from the mother "in the first part" the author takes up dystocia due to the foetal annexes. The third chapter is then devoted to ergot.

Prof. Charpentier has given us, indeed, a valuable thesis on the history; physiological action; indication for the administration; (alluding of course, to the allopathic principle) and last, "the administration" of ergot.

"While we have, in a paper, read before the Institute at St. Louis by Dr. H. C. Allen, a truly valuable contribution on this subject, it is only interesting to those who regard the study of ergot from the standpoint of a homœopathic practitioner. Dr. Allen gives a fair report of the history of the drug, placing it among the thallophyta group—cellular or non-vascular plants—the lowest form of spores, having no sexual reproduction, but he omits (regarding it sacrilegious no doubt) the physiological effect, an important factor in the careful study and appreciation of any remedy. We haven't the space to give the "indications for its administration" as understood by our allopathic brethren, nevertheless the rules laid down are excellent ones to follow when expedients are absolutely required. Professor Schweder, of Ber-

lin, now dead—God bless his memory—always taught his students to observe the following rule with regard to the administration of ergot : “Never give ergot until both child and placenta have been delivered.” Charpentier adds, “The first thing to do in case of hæmorrhage is to empty the uterus of the placenta and the contained blood.” If “ergot be given before this, by causing contraction of the cervix it may oppose this, therefore again, never give ergot as long as the uterus contains any thing. The rule is absolute in cases of hæmorrhage due to inertia after delivery, but we never give ergot, only after the uterus has been emptied of clots.”

Vol. IV. The fourth and last volume of this wonderful compilation and translation of cyclopædia of obstetrics and gynæcology by Dr. Charpentier is now before us and although last is by no means least in interest or value. The volume is divided into two parts, twelve chapters in the first, devoted entirely to obstetrical operations and the last part has five chapters giving the pathology of the puerperium. Chapter I considers version ; Chapter II forceps delivery ; Chapter III. the filet ; and the balance of the chapters to the lever ; induction of artificial labor ; induced miscarriage ; Cæsarean section ; Porro's operation ; post-mortem Cæsarean section ; delivery, *per vias naturalis* ; symphysiotomy and embryotomy.

The last part is devoted to “The pathology of puerperal fever,” forms of diseases ; pathological anatomy ; prognosis ; treatment.

This volume is without doubt the most complete work yet published on the subject.

THERAPEUTIC METHODS : an outline of principles observed in the art of healing, by JABEZ P. DAKE, A.M., M.D., Nashville, Tenn., published by OTIS CLAPP and Son, Boston, 195 p.p.

When Otis Clapp and Son go sponsor for a medical work they not only guarantee that it shall be one of merit, but you may rest assured the mechanical part of the book will be faithfully carried out in every case and Dake's lifework of “therapeutic methods” is no exception to the rule. The author has placed the profession under great obligation for this truly valuable work, for when life's hoary finger-marks of time adorn the head of one who is willing to impart to his brethren the accumulated harvest of years, gathered amidst many winters' storms, how much more acceptable is the treasure than one which has sprung from an ambitious but young mind, garnished only by a desire to appear in type more than the desire to add strength to our literature. Would that more of our older members could have the rare gift—almost providential—to leave us the concentration of a half century's experience obtained at the bedside instead of the many existing hypo-

theses, evolved from imaginative minds inadequately stored with practical knowledge or furnished with erroneous precepts. Dr. Dake has attained that most necessary habit—only acquired by true cultivation of mind—of observing accurately, of carefully noting minute differences, and of scrupulously registering them. In his work there is, as it were, an extraction of the essential out of the particular, a sublimation of the concrete, and a farther elaboration by which these essential ideas supersede the concrete ideas, with the result of adding power to his "Therapeutical Methods."

The author has divided the contents into three parts. The first giving the "history of therapeutic methods and system" from the time of Pythagoras and Hippocrates to that of Hahnemann, Ling and Priessnitz, which is followed by the somewhat peculiar title of "admitted prerequisite" including a consideration of the importance of a thorough knowledge in therapeutics (to which we say amen) of anatomy, physiology, pathology, ætiology, symptomatology, pathogenesis or materia medica.

Part second. Therapeutics: empirical, theoretical and scientific, physiological therapeutics, chemical, mechanical and anti-parasitic methods and means, pathogenic therapeutics, antipathic, allopathic, isopathic and homœopathic relationship.

Part third. The demands of *similia*, which includes: 1. A positive drug symptomatology. 2. Drug provers and proving. 3. Drug symptoms. 4. Symptoms recorded. 5. Application of *similia*. 6. Posology. 7. Pharmacy. 8. Environment and habits. 9. Constructive homœopathy. 10. Non-medicinal homœopathy. 11. Adjuvants. 12. Conclusion.

SOME THOUGHTS ON A NEW REMEDIAL SOURCE, with a working hypothesis suggestive of a more radical treatment of chronic diseases; also some therapeutic deductions from comparative pathology, by CHARLES FRANCIS RING, M.D., Ward's Island, New York.

Organic chemistry is of such a variable nature; changeable with every radical change of the body, as life and death, based upon nothing more tangible than a hypothesis, that we cannot depend upon any changes as positive or assured of facts more reliable than conclusions formed by a highly cultivated mind which is endeavoring to lead us out of darkness into a light more acceptable than we now have upon therapeutics. "We do not at present know any thing definite about the molecular composition of active living protoplasm." Vital activity of all life is of three kinds, nutritive, formative and functional. The author states that "The attempt of Schüssler to introduce, as an abridged system of therapeutics, the inorganic tissue formers has not resulted in

enriching the *materia medica* to the extent hoped for—nay, claimed—by its author, much less supplanting the elaborate system of minute and varied drug symptomatology created by Hahnemann and his immediate followers.

Schüssler's sweeping assertion that these twelve inorganic tissue remedies are quite sufficient "to cure in the shortest way all diseases that on the whole are curable," certainly displays a narrowness of mind and a lack of impartial judgment not usually found in a true philosopher. Had he included in his therapeutic system the proximate principles of all classes, he would have, we believe, with his superior knowledge of chemistry, reclaimed a *terra incognita*, upon which we can only hope to throw an uncertain light, and carried our school of medicine to a point which "our friends, the enemy," with their present scientific method are incapable of ever attaining. It is on this line, so abruptly terminated by Schüssler, that we will endeavor to turn our thoughts at this stage of the subject."

"The organic substances," Schüssler tells us, *New Treatment of Disease*, p. 11, "are only influenced by inhaled oxygen, and by the inorganic salts. Nitrogen and carbon, therefore, remain useless as therapeutical agents. If in the animal organism nitrogen should or could be wanting, then albuminous substances would be wanting, of which nitrogen is an integral part. Without entering into consideration of Schüssler's objections to the organic physiological constituents for therapeutic purposes, we will now give a brief outline of some of them, going more into detail when we come to consider the treatment of disease."

The writer then quotes the more modern works of Flint, Forster, Carpenter, Liebig, etc., as follows, on physiological chemistry and of thudichum or the chemistry of the brain albumen of blood; cholesterin, haemoglobin, keratin, leucin, tyrosin, kreatin, kreatinin, sarkosin, xanthin, carnin, inosit, cystin, uric acid, guanin, allantoin, cerebrin, lecithin, protagon, neuro-keratin and phenosin.

We haven't space to give a more elaborate notice than this brief mention of a work of this character and yet accepting the work as a compilation of the deeper thoughts of the chemistry of the body and our therapeutics it is indeed a valuable thesis to have and we congratulate Doctor Ring upon his masterly collection of theories regardless of their adaptability to our every day work in the practice of medicine.

PUBLICATIONS OF THE MASSACHUSETTS HOMŒOPATHIC SOCIETY.
1886. Vol. IX.

The good work done by our medical societies becomes more manifest every year in the stamp of individualization placed upon

each contribution. Medical societies are no longer a mass, an aggregate of medical mankind, but each member has become differentiated, passing out of the nebulous condition of the whole and becoming stellar. Each man counts one; the units stand apart; and the nebulae break into stars in the sky of Homœopathy. The lessons of individuality and of freedom from empiricism descending from the luster of our early teachers are caught here and there and reflected in a far-reaching gleam that sheds light upon the path-way.

Thus it is that the reports of our state societies are always among the welcome visitors to our shelves. In this particular instance following the president's addresses and the report of the necrologist, the committee on climatology is well represented in "Ozone, its relation to health" by E. U. Jones, M. D.

In clinical medicine, E. P. Colby, M. D. presents an interesting paper, "Notes on Hysteria," which derives especial value from the diagnostic points of Ross.

At the October meeting the use of "antipyrin in Fever," received a well deserved rebuke at the hands of J. Heber Smith, M. D.

The bureau of surgery reports five articles of much value. Most interesting to us is the report of the committee on gynæcology which appears in the published proceedings only represented by an article on "Prolapsus uteri, causes, etc.," by L. A. Phillips, M. D., Boston.

The recording secretary reports also the reading of a paper by A. Boothby, M. D., on "Surgical treatment of prolapsus uteri," but the printed proceedings fail to account for it. Dr. Philip's paper is, of course, a good intelligent and comprehensive treatise of that old time subject "prolapses" and while not particularly interesting to the specialist will be found acceptable to the general practitioner.

SOCIETY PROCEEDINGS.

BUREAU OF PAEDODOLOGY, MICHIGAN STATE SOCIETY :

Dr. Cooper read a paper on Marasmus.

Dr. Randall—I would like to know the comparative results of treating such cases therapeutically, rather than attending so closely to the diet. I had a case once, a child eleven months of age. Had had diarrhoea the most of its life ; was pale, weak and fretful ; its head sweat profusely, so much so as to wet the pillow around its head when sleeping.

The first time I was called I prescribed calcarea carb., 5th decimal, 12th and 30th, one dose of each. The child slept better

after they had followed this prescription, and they wanted it renewed ; it was done ; there was not a word said about the diet, but it became as plump and hearty as any other child. Frankly, that was a good case for the diet to be looked after. I neglected to do it, but the result was good.

Dr. Cooper—I would like to say that a case I met this morning, after carefully examining the child, I examined the nursing bottle. They were feeding the child upon Horlick's food, and putting it in the nursing bottle. I took out the tubing, and pulled it apart, and I found that the nipple was full of rancid milk, as was also the case between the tubing and the nipple. I found that full of rancid milk. I know no child could recover with such food as that ; they could not live upon such stuff. That is where we fail in so many cases, and we lay the fault to our remedies. I took pains to show them how to clean the bottle, and I changed the food to cow's milk.

Dr. Randall—I would like a discussion of the relative merits of the different foods. Perhaps those who are opposed to cow's milk have not used it right. I have had considerable experience with the different foods ; I began with Horlick's and Ridge's food. I have had some experience with Nestle's condensed milk, and have been led to give my preference to Nestle's, and also Carnrick's food.

Dr. Cornell—I have used largely of the prepared foods, but not with success. I have used the condensed milk, but in my opinion there is a tendency to acidity, which renders them unfit for use. A case came under my treatment the other day. The child's condition was very similar to that of Dr. Cooper's first case. They had been using condensed milk, Nestle's and others ; the child was weak and fretful ; there was constant vomiting, and the stools were green. I am a firm believer in cow's milk, where it comes right from the cow, and not from the hydrant ; the cow must be well fed, not slop fed, and the condition of the pasture must be taken notice of. I put the child on the milk of a good cow, fed on the best of grass, and it got well.

I had a case last summer of a child with cholera infantum. I asked what food they gave it ; they said cow's milk ; I found it was from a cow pastured on low grounds, getting weeds instead of good grass, and it was this that produced the diarrhoea. I had the child put on milk from cow pastured on the high land, and the child got well. I think the milk should be tested with litmus paper, to find the state of acidity. I say cow's milk is better than any condensed milk, that is apt to become acid from the tin.

Dr. Wood—One point I have been waiting for some one else to bring up, which is intimately connected with this matter of dietetics. Dr. Crank wrote a very interesting paper on the subject

of oils in connection with infant diet. He emphasizes strongly the usefulness of oils in those cases of marasmus where the child will run down in spite of any thing, and diarrhœa sets in. Under circumstances of that kind where Dr. Cooper boils up his dried beef, Dr. Crank would use the oils, giving a few drops in milk, for older children increasing the quantity. I have had experience in the use of oils in food, and can see no objection to them, but much in their favor. It is simply a question of diet, and why cod liver oil has become obnoxious I can not say, unless it was the excess to which its use was carried in the allopathic practice.

In the discussion of Dr. Crank's paper, the question was brought up as to the use of the oils where the children are so delicate that they can not assimilate them through the stomach. You then rub the child over, with pure olive oil, for instance, in the groin, and cover the surface of the body, and you will find the effect most satisfactory. In the first place, you administer a food, in the next place you are protecting the child from draughts of air; these children are very susceptible; it acts, then, as a protecting agent, as well as an article of diet. One physician stated that he had found the fat of the lamb an exceedingly useful agent, melting it. Another used mutton tallow, and another beef tallow, and Dr. Owen, Sr., wanted to know what advantage these had over giving the child a rind of cooked smoked ham; and that would be a good thing in many cases. It is surprising how the little things will grab a piece of ham rind. The little things will go to sleep with one end in their hand and one in their mouth. What I want to emphasize is that the child wants the right kind of food, given to it in the form most easily assimilated and administered, and cod liver oil is this. There is an element in the cod liver oil which you do not get in any other; it seems to act better; to assimilate better, and it is a question of fact, that in the hospitals of Europe, and in the seaport towns especially, where they can not very well get any thing else, they take cod liver oil in the emulsion and spread it on bread, and give it to the children, and they begin to improve at once, and improve faster than on any thing else. As a rule children should not have starchy food until after teething. And here is another fact, when the child vomits its food, or it is found in the stools, bound together in masses of curdled milk, take gum arabic and dissolve, and give the child; it acts in a purely mechanical way, and you will find it very beneficial. So far as the nursing bottle is concerned, I can fully endorse what has been said here in relation to it, and what Dr. Donaldson says in his work—the best nursing bottle is a teaspoon and clean cup.

Dr. McLachlin spoke in favor of the use of cow's milk.

Dr. Arndt. Of the many excellent points made by Dr. Cooper, I

would speak of the necessary care in preserving perfect and absolute cleanliness, and changing very often from the mother's milk to cow's milk ; as far as my experience goes, I can say that I have found always the marked superiority of good cow's milk over any thing else. I fully agree that cod liver oil in such cases is not only likely to benefit the child because it takes the place of food, but because in many cases it produces corrective results. It is more especially active in that direction when used in cases of a scrofulous condition, I carefully examined the record of cod liver oil as a remedy, and was surprised by the lack of knowledge as to its valuable properties. You have noticed that an attempt has been made to attribute its value to the iodine it contained. In whatever relation it stands to the scrofulous diathesis, and humours, remedies must be used holding that very relation to this blood taint.

Dr. House—It has been my experience that before the period of dentition these prepared foods, are as a rule, obnoxious to give to any infant. And if the mother's milk was not agreeable to the child, that cow's milk should be substituted. There may be cases where the child was born with some constitutional taint where they need treatment, to overcome it, and even then I think the cow's milk will be sufficient. But after they have passed the period of dentition prepared foods are good. I have in cases of intestinal catarrh very successfully used Horlick's food. In regard to Dr. Brown's experience, I had a similar one, the lady was confined recently with her second child. The same thing occurred in her first child ; it became so cross and peevish, and the symptoms of colic were so strong that I was called. The medicines I prescribed, were of no avail ; but by changing its diet and giving it cow's milk, the child grew hearty and well. The case of the second child was a recent one. The mother attempted to nurse her child, and there was resultant trouble, remembering the former experience, I changed its diet, giving it cow's milk, and the result was favorable.

BUREAU OF GYNÆCOLOGY. SUBJECT FOR DISCUSSION : " AMENORRŒA."—Dr. Wood. Dr. Hartson has the division " Emansio Mensium," Dr. Porter the division " Retentio Mensium. We have also voluntary papers, by Dr. Grant, and by Dr. J. C. Nottingham ; Dr. Hartson read his paper.

Dr. Wood—You know what Dr. Dunham said about the treatment of tonsillitis, to shut the patient's mouth and make the prescription. What Dr. Hartson has said about the use of electricity is to the point ; it is necessary in many cases to bring about local stimulation ; not forcing the menses in resorting to the emmenagogues of the old schools, but stimulating the uterus and ovaries. Our treatment should be directed chiefly to that, and to detecting

the cause or causes of the suppression. I desire to speak of how to discriminate between pregnancy and suppression of the menses. First look at it from a medico-legal standpoint : The old English law was that when a woman was condemned to die for any crime, if there was any cause why execution should be staid, she was permitted to live until the subject was decided ; for instance if she was with child, the execution should be staid ; not only must she be pregnant, but be quick with child, the state of quickening had to exist before execution could be staid. In New York, and in states where capital punishment exists, we have a board of matrons to determine whether the condemned criminal is pregnant. In France the period of quickening is not made a condition, if the patient is pregnant, that is enough ; if she is carrying a living foetus, whether the period of quickening has arrived or not, that is enough. And again, we are called upon to make this discrimination where a woman's husband dies, and she is pregnant with a child which may be the heir to an estate, we are often called in such cases to make the distinction ; and then in cases of seduction, and in cases of malpractice where the physician did not recognize the existence of pregnancy, when we may be called upon to distinguish before our courts. And in climaxis, and in instances of lunacy, and of religious impostors, such as the case of Joanna Southgate, I say these numerous cases make it necessary to discriminate between pregnancy and suppression of the menses. Now there are other cases almost superfluous to mention in a meeting of this kind.

Etiology. Suppression may be induced by a sudden cold ; by moving from one altitude to another. A physician practicing in Colorado told me his greatest difficulty was with this form of amenorrhœa. It also results from mental conditions, excessive joy, grief and fright, are a frequent cause for suppression. Again, suppression often exists for some little time after marriage, when the patient is not pregnant, but from the new relations which exist ; it not infrequently exists from illicit intercourse, the menses being suppressed for some time. We get it from superinvolution of the uterus, from hemorrhages, mechanical causes, ovarian difficulties, ovarian tumors, though if only one ovary is affected it may not exist. And we get it from cachexia ; and from some idiosyncrasy, sometimes from the slightest exposure of any kind ; in early climaxis, and also where the menses appear early in certain families.

The symptoms vary from the slightest malaria, to the most severe convulsions : not infrequently the most severe convulsions result from the suppression. So I say that suppression is not infrequent when a diagnosis is made for pregnancy, and it is a well known fact that pregnancy sometimes occurs where a woman

has never menstruated ; in some cases women have never menstruated until pregnancy. In other cases the woman will menstruate during the entire period of pregnancy ; and then again we get the two simulated ; where a woman wishes to become a mother, and if a girl becomes pregnant and wishes to conceal the fact, she can stain her linen, etc.

One of the symptoms of pregnancy is the morning sickness, occurring from the second to the sixth week ; this is not a positive symptom, for there are other causes which occasion these symptoms. In cases of cerebral affections ; in renal affections when we get uremia. And then we know it results from dram drinking, women addicted to the use of strong drink, are apt to have vomiting, as well as in connection with pregnancy. Another symptom we have to rely upon is the mammary change. They become hard and knotted, but we do not get the decided changes until the end of the second month, the formation of the areola being much more decided in blondes than in brunettes ; the formation of the areola, and later of the secondary areola. These would seem to characterize pregnancy ; but there seem to be other cases where they are present ; in ovarian and uterine diseases, in sexual diseases of any kind ; it seems that after milk begins to secrete in the glands, would be a good time, but we get secretions of milk in more cases than pregnancy, from men, and from children ; simply from irritation of the breast ; in other cases pregnancy may run its entire course without mammary secretions. Next we get the abdominal changes ; usually during the first six weeks of pregnancy the abdomen is contracted and about the fourth month it begins to increase, and the uterus passes into the pelvic cavity, then the umbilicus becomes prominent, and at the end of the eighth month the uterus settles down again ; but the shape of the attachment is peculiar ; you get the so-called puriform shape. First then, comes the contractibility, then the enlargement of the abdomen ; in cases of inflammation it is necessary to make this distinction. There are certain changes in the uterus, and vagina which I will not dwell upon, only one important change in the vagina, has attracted the attention of the profession during the last few years, a peculiar pink tint which characterizes pregnancy, and no other period. And then you get them with the calculi, and in antelexio uteri ; and again in the uterine souffle, when the fundus may fall back upon the finger in such a way as to indicate pregnancy. It would seem that the sensations of quickening would surely indicate pregnancy, and yet there are a number of conditions that simulate this ; for instance, flatulency of the bowels, or where we have dropsy, also where we have uterine and abdominal contractions of the abdominal muscles, and so in cases of super-involution, taken in connection with pain in the super-

pubic region. We have also the foetal heart sounds heard in auscultation, and even this may be confounded with other conditions. And then the kystein in the urine, and this also is not a positive sign being present under other conditions. During the first month of pregnancy in making our diagnosis, we cannot rely upon suppression. The morning sickness occurs between the fourth and sixth week, the decided mammary changes begin from the third month, decided changes in the abdomen do not take place during the first two months, sometimes into the third month; the quickening does not take place usually before the fourth month, sometimes not until the fifth. The ballotment, from the fourth to the seventh, sometimes simulated by ante flexion. The foetal heart sounds are not heard usually, before the sixth month, though it is possible for this to disappear while the child still lives, the kiestein exists in the urine during the seventh and eighth.

In the treatment of suppressio mensium, of course if it is due to obstructions of any kind, we have to resort to mechanical or operative measures. If it is acute in character, and the patient suffering from acute pain, to place the patient in a sitz bath, or put her feet in a hot bath; it frequently gives great relief to use an injection in the form of a vaginal injection. Dr. Ludlam recognizes this as a useful agent for removing the obstruction which causes the suppression; it is a good way to introduce the sound before the menstrual flow.

Treatment.

Cold; Bell., Aconite, Gels., Dulc.

Perspirations; Cuprum, Aconite.

Weather: Rhus tox., Dulc.

Wet Feet; Aconite, puls.

Fright and chagrin; Opium, Coffea, Verat. Ver.

Pectoral symptoms; Calcarea, Phosphorus.

Hysteria; Macrotine, Moschus, Hyosciamus, Ignatia.

We will not want emmenagogues, unless we call them homœopathic emmenagogues. Manganese used to be the great remedy, but they are getting out of the way of that now.

Where you have a case of suppression it is necessary to watch the patient carefully; place her in bed, and encourage the flow by the means I have indicated, hot baths, injections etc., and use the remedies indicated; you may prevent her from becoming a permanent invalid, which unless care is taken she is likely to become.

HOMŒOPATHY VERSUS THE KNIFE DURING THE EARLY STAGES OF DEVELOPMENT OF OVARIAN CYST. By A. B. Grant, M.D., Ionia, Mich.—During the early part of February, 1886, I was called upon to prescribe for Mrs. W., of this city, who gave

me the following brief history of her case : Age twenty-seven ; married seven years ; had one child six years ago, now dead ; has never had a miscarriage ; menses have always been regular and painless, in fact, general health good ; weight 145-150 ; nervobilious temperament, dark brown eyes.

About four or five weeks ago was injured by a kick in her right side, just above the crest of the ilium, inflicted by her so-called husband. Present symptoms : Fever, temperature $101\frac{1}{2}$ - $102\frac{1}{2}$ ° ; great thirst ; tongue heavily furred, yellowish-brown ; extreme restlessness with nausea and vomiting at brief intervals, and very tender and sore over right illiac region. [All of these symptoms against an ovarian cyst.—ED.] Diagnosis, typhlitis, possibly circumscribed peritonitis. The soreness gradually extended to the "left side," the abdominal muscles becoming quite rigid and tense. The nausea and vomiting subsided in two or three days, but the pain and fever continued about two weeks. Soon after convalescence, I discovered upon a digital examination an enlargement of the right ovary, which at that time was quite sore and sensitive to touch. It grew rapidly, and at the end of six weeks it was as large as an ordinary hen's egg. For the satisfaction of having my diagnosis—ovarian cyst—verified, I called Dr. T. R. Allen, of this city, who made a thorough examination and immediately pronounced it an ovarian tumor. The pulse at this time, and for several weeks, was running from 108 to 114, with a normal or very nearly normal temperature. [No ovarian cyst.—ED.]

The patient was placed upon apis and conium, and, with the exception of a few doses of sulph., continued on these remedies, three doses per day, for about four months, when the tumor had entirely disappeared. The patient, to-day, is in the full enjoyment of perfect health. What relationship the injury referred to had to do with the etiology of this case, I will leave for you to judge. But I have no doubt in my own opinion, however, that the inflammatory processes which gave rise to the development of the tumor were directly caused by the injury. [More properly stated : symptoms of pelvic hematocele.—ED.] My first impression in this case was to operate at once. But, it offering such a splendid opportunity for a test case, we concluded to try the efficacy of homœopathic remedies, with the results as above stated.

Dr. Allen informs me that he has aborted and dispersed two cases of ovarian tumors by the persistent use of internal remedies.—Voluntary Report read before the Homœopathic Medical Society of Michigan, convened at Lansing, May 17 and 18, 1887.

[As a lesson : The above case can scarcely be called an example. The doubt in question, relating to a correct diagnosis, is so apparent, we are afraid the report will have a re-actionary effect, rather than a case of "point in hand," when discussing the sub-

ject of "curing ovarian tumors." When an "error in diagnosis" is associated with a report of spontaneous cure of an ovarian cyst, it weakens the "case before the jury." In justice to Dr. Grant, we quote part of a letter received from him after the paper had been sent to the printers: "If you do publish the paper, change the word 'cyst' to 'tumor.' I sat down one evening just before meeting, and scratched it off without looking up the special pathology. Yours, GRANT."—ED.]

Dr. Brown.—Dr. Grant's case strikes me as being subject to another construction than that of an ovarian cyst or tumor; perhaps it was a hematocele, instead of a tumor, as coming from an injury. In regard to Dr. Hartson's paper, that part of it in which he speaks of the use of electricity, I believe that it is a neglected remedy in connection with diseases of the rectum, uterus, etc. If we had a patient pyemic, that had not the blood, we would expect to build up the system and get good blood first; and in the cases under consideration, we want to stimulate the organs to bring on this condition; to remove the obstructions which cause the suppression. I have used electricity in chronic suppression, cases where they have run for months. I had a patient that was fleshy, and at the same time anæmic. She had been treated for two years by good physicians. I tried the remedies first without avail, and then tried the batteries, alternating between the galvanic and the voltaic. I did this under the suggestion of Dr. Butler, but I like the voltaic better. The effect was very good.

Dr. Grant.—I will say that we looked up in the case I described, the diagnosis of hematocele, or those possible results that might arise from an injury in that location, and we did not think it was an hematocele; and furthermore, we did not find any record of an hematocele from an injury. I would like to know how you would get the absorption from an hematocele? We can conceive how we could get it from a cyst in the mucous membrane.

Dr. Wood.—How do we get the puratic secretions? I have seen them dispersed in the case of fibroid tumors, and I have seen them disappear under the use of electricity. Sir Spencer Wells, and Sir J. Y. Simpson cut into what they had diagnosed as an ovarian tumor, and found a pregnant fœtus. It may be that the diagnosis of an ovarian cyst was the correct one, but we are to be careful how we assert that we removed such a thing as that by internal remedies. For hematocele I think the best remedy is the use of hot water in the vagina. If it had been an hematocele, I think the authorities would agree with me that it is possible for it to be absorbed.

Dr. McLachlin.—I think it possible that hematocèles might be absorbed. In one case where the menses was suppressed, I

have never met one like it since, or any other physician that had. It occurred early in my practise. I was called to see a lady forty-six years of age ; quite fleshy ; she presented all the evidences of labor, having intermittent pains from every three to five minutes, and great bearing down. Two weeks before I saw her, she had been visited by a physician to confine her ; he had given the diagnosis of pregnancy, and after waiting a few hours, went home saying that if she was not delivered that night she would be within two or three weeks. I made an examination and found no evidence of a pregnant uterus. I questioned her and learned that about nine months previous her husband had left her ; that she had suppression then ; had been regular before ; and that she had presented many signs of pregnancy from that time on ; I made one more minute examination and found no evidence of pregnancy. The next day I found her quite comfortable, and examining with the sound found nothing ; the abdomen was distended ; she had arrived at the conclusion by this time that she was not pregnant.

Dr. Cornell.—I was engaged to see a lady in confinement whom I had never seen and I did not see her until some time after she should have been confined. I supposed she had called another physician, but three months after the time she should have been confined, she presented herself at the office very much distended, and wondering why she had not been confined. Upon examination I found her not pregnant, but suffering from a retroverted uterus ; she was hysterical ; she had previously given birth to a child, then three or four years old. She was surprised at the result of the examination. The retroverted uterus was put in place, and inside of two weeks the distention entirely subsided, and since that she has given birth to a child.

Dr. McLachlin.—In the case I referred to the symptoms were very decided, hard intermittent pains as severe as any labor pains, and coming with such force it seemed as though the uterus would be expelled from the vagina.

ABSTRACTS.

—SCHÜSSLER'S REMEDIES IN DYSMENORRŒA.—D. B. WHITTIER, M.D. POTASSIUM PHOS.—DYSMENORRŒA WITH NEUROSES.—Miss L., aged twenty-eight. Keenly sensitive; pale; lachrymose; possessed of a morbid mentality induced by years of suffering from pain and hard circumstances in life; consequently had great mental depression and exhaustion; intense but smothered emotions; dread forebodings and impatient of life's hardships; a struggling toiler without home and helping friends; wanting sympathy and counsel, and finding none. She fought well a pronounced hyster-

ical nature until nerve and will power succumbed to physical pain. The neurotic outbursts were intense and painful. She menstruated at the age of thirteen, was irregular for one year without unusual discomfort. For fifteen years subsequent she experienced the following pains more or less severe together with the nervous and neurotic conditions cited. Two weeks preceding the menses the *mammæ* were so painful that the touch of her clothing was unbearable.

The menstrual pains were cramp-like with severe bearing down in the hypogastrium, and most severe after the flow commenced; was obliged to take to her bed and remain there for three or four days.

During the menses, when the suffering was most intense, a sharp shooting pain would extend from the hypogastrium to the epigastrium, followed by a sensation, as if something were flowing up to the stomach, and immediately succeeded by vomiting of bile or frothy acid substances sometimes streaked with blood. The vomiting would relieve the fearful distress at the stomach, when the uterine pains would be increased, and sometimes continue for twenty-four hours.

The headache was at first general, but soon settled over the left eye, and continued for two or three days. When it was severe the pains elsewhere were lessened, and *vice versa*.

For the past few years the headache has occurred more frequently usually during the flow. Menses were five or six days duration; flow not excessive, thick dark, and coagulated, sometimes resembling flesh, the passage of the same causing intense pain. The number of the substances has decreased of late years.

This brief recital contains only the prominent, more severe and constantly recurring menstrual symptoms; the details of minor and intervening conditions are purposely omitted on account of her hysterical inclination. Cervical stenoses could not be assigned as the cause of the dysmenorrhœa, as the passage of the sound was easily made, and an occasionally monthly period was observed with symptoms much less intense. During the past few years the most severe periods have occurred less frequently when the head aches were more intense. In 1883 five times; 1884 four times; and in the seven months of 1885 four times, with several other months when she was very sick. These periods of such agony, which was only slightly lessened by medicine, have been her lot for fifteen years. Sleepless nights have resulted, together with mental anxiety, nervous exhaustion, and despondency. For years previous tonics, nervines, and anodynes had been given, with only temporary benefit. I gave the medicines apparently indicated, most prominent of which were bell., gel., *cimicifuga*, *ignatia*, puls., *colocynth*, *caulophyllum*, and *viburnum*, with no satisfactory

results. I became discouraged, and the patient lost all hope of benefit.

Dr. Schüssler's medicines came to my notice. The objective and subjective, symptoms of the case were like a transcript of the indications for *kali phos.*, and I concluded to use it in the 6x.

It was prescribed night and morning for six months, then once a day. The first menstrual period following the use of the medicine was comparatively comfortable, and after three months she experienced very little discomfort. There was progressive improvement; had but one painful period in a year; normal flow has returned; better mental equipoise; strength greatly increased; returned to her avocation as seamstress without a return of her former complaints. She expresses herself gratefully as having experienced a wonderful change in mind and body.

—MAGNESIUM PHOS.—The indications for this medicine are: all ailments of a spasmodic nature; warmth is soothing; neuralgic cramping pains, worse by motion; colic; spasmodic coughs; worse at night; whooping-cough, and the chief remedy in menstrual colic.

—DYSMENORRHOEA. Miss S., aged twenty. Nervo-sanguine temperament; menstruated at twelve years of age and for six years menses were normal; eighteen months ago had suppression from a cold when pelvic inflammation ensued, and was aggravated by a fall down-stairs four months after; during the skating craze, was in daily attendance at the rink.

For eighteen months she has had menstrual colic; periods regular and flow normal; severe cramp pains in hypogastrium, causing the patient to toss and roll about upon the bed, and the constant application of hot fomentations for twenty-four hours; had pains extending down the legs; backache; heat in the back; and in the menstrual intervals, dragging and tired feeling in the pelvis. Physical signs by touch were prolapsus uteri; by speculum, endocervicitis, and cervical erosion; by the sound, unobstructed canal, measurement of womb two and a half inches.

Bland albuminous leucorrhœa has increased for the last six months.

Applied glycerole of flu. ext. of belladonna, twenty drops to the ounces, and prescribed mag. phos., 6 x., three doses daily.

Five days after, the menses appeared, and surprised both patient and friends by the diminished pain, quite one half, so that she had comparative comfort, and the attendants were relieved of the constant application of fomentations.

The amelioration of this period was followed by relief of backache, and a very noticeable lessening of the leucorrhœa, and has remained so since. Relapses occurred in this case, when the periods would recur in the usual severity. Other remedies were

given for a time in hope of a more speedy cure, but were less satisfactory than the mag. phos., which was again administered morning and night. Occasional applications of a solution of chlorate of gold and sodium were made to the cervical canal. The patient is now well after five months' treatment.

Publications of the Mass. *Hom. Med. Soc.* Vol. IX.

—APPARATUS FOR MAINTAINING THE LITHOTOMY POSITION. By THOMAS B. MCBRIDE, M. D., of Phila.—I desire to present to the society, this evening, an apparatus I have designed for the purpose of supporting the limbs and maintaining the lithotomy position.

It consists of a piece of hard, elastic wood, preferably ash or hickory, 3-8 of an inch thick, 1 inch wide, 36 inches long, bent at each end in a semicircle of 6 inches diameter, or a semicircumference of $10\frac{1}{2}$ inches, thus leaving a shaft of 15 inches between the semicircles, and making the finished length of the instrument 27 inches ($6 + 15 + 6$.)

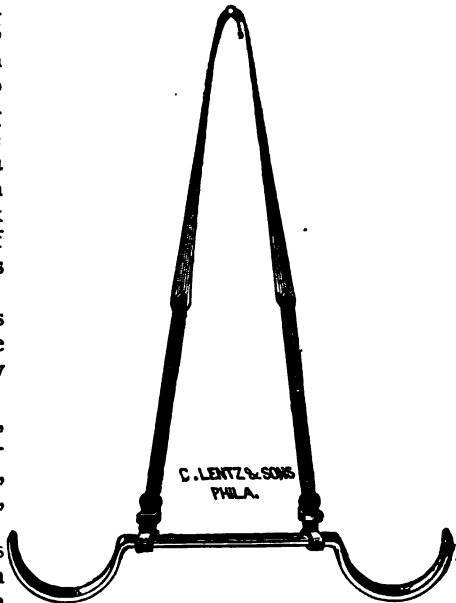
To the shaft, 2 inches from each end, a buckle is immovably fastened by means of leather.

A band of webbing, finished at each extremity with a leather strap, the whole 50 inches long, completes the device.

In using the apparatus the thighs are flexed on the abdomen and put in the semicircles, the band is placed around the neck and fastened to the buckles.

The advantages are apparent. Its cheapness places it within the reach of every one. The thoroughness with which it does its work, keeping the patient immovably in the lithotomy position, and maintaining the same relative position of the parts; the fact that it does not interfere with the circulation; the strength, lightness, and remarkable simplicity will, I think, render it a valuable acquisition to the surgeon and gynæcologist.

—NEW VARIETY OF CYST OF THE LABIA MAJORA —Cysts of the labia majora are comparatively common, when due to inflam-



mation or hematomas following labor, or to obliteration of the duct of Bartholin's gland.

Congenital cyst of these parts are extremely rare, or their existence would have been noted and their characters studied.

A case of this kind has, however, been noted by Dr. Felix Lagrange, who gives the following description of it :

It occurred in a female, 27 years of age, of sound health. In 1878 she noticed that the size of the right labium was larger than normal. The increase in size continued till 1881, when the patient discovered the increase to be due to a tumor the size of a nut, painless, and not interfering with walking or the genital functions.

In 1883, after straining at stool, a slight discharge like leucorrhœa appeared, and was proved to proceed from the cyst, which, nevertheless, retained its former size and appeared to be stationary until March 1885.

At this time she consulted a doctor, who recognizing the large size of the labium, punctured it and then injected chloride of zinc.

The patient was obliged to keep in bed for three weeks, and eight days after getting up another injection of chloride of zinc was made. Abscesses formed and were opened.

In October the tumor had reached the size of a fowl's egg, and occupied almost the whole of the upper part of the right labium. It was elongated, ovoid, and gliding with ease in the cellular tissue of the region. It was impossible to find the opening from which the leucorrhœal discharge came.

On October 20, the cyst was removed. During the operation the cyst-wall gave way, and there escaped a whitish fluid without any special odor. Recovery was rapid and complete.

Anatomical examination of the cyst. The milk-like fluid was not examined clinically. The cyst-wall was composed of a fibrous layer two or three millimetres in thickness, with numerous blood-vessels. Scrapings from the cyst-wall showed two kinds of epithelium.

(1) Stratified pavement epithelium.

(2) Cylindrical epithelial cells with vibratile cilia.

Sections made at right angles to the wall of the cyst were stained with micro-carmin and mounted in balsam or glycerine.

The wall was made up of fully-formed fasciculated fibers and very many blood-vessels with here and there *culs-de-sac* of the vulvo-vaginal gland.

The innermost-part of the wall was infiltrated with numerous embryonic cells, pointing to a recent inflammation. This was caused by the injection of the chlorate of zinc.

The epithelial covering was the part presenting most interest, showing as it did the two varieties of epithelium already mentioned.

The ciliated epithelial cells were found on the lower part of the cyst wall, that is to say, on that part of the wall nearest the ischium. They formed there a continuous covering, but of unequal thickness, in some cases ten or twelve deep.

That layer of cells in immediate contact with the connective tissue was composed of large cells irregularly placed, deeply colored by carmine and pressed one against the other. Upon this layer were placed cells of a transitional variety, while the innermost layer was composed of cylindrical cells with cilia.

The cilia themselves were plainly visible, though they were not present on all the cells, but this can be explained by the former history of the tumor.

The other sections had stratified pavement epithelium on their inner surface, which was evidently a lining derived from the external coverings.

These two varieties of epithelium point to the cyst having a double origin.

The stratified epithelium was evidently derived from an invagination of the skin, while the ciliated cylindrical epithelium was derived either from the canal of Wolf or Müller, two canals which are developed in this region. The canal of Wolf generally atrophies and forms, especially in the cow and sow the canal of Gartner. In some very exceptional cases, however, they remain patent as small epithelial tubes, running along the side of the uterus, and descend as far down as the vestibule of the vagina, so that the cyst above described may possibly have been the remains of this canal.

Against this view, however is the fact that the canal of Wolf does not contain ciliated epithelial cells.

The canal of Müller forms the vagina, uterus, and tubes, the last two being lined with ciliated epithelium, and though no physiologist has yet discovered this variety of epithelium in the neighborhood of the vulva Dr. Lagrange is of the opinion that, as these cells are found at the upper part of the utero-vaginal canal, one may reasonably admit their existence at the orifice of the genital canal, especially at the beginning of intra-uterine life.

In conclusion, he believes this cyst was developed at the angle of the genito-urinary sinus and cutaneous wall by a bud-like process of epithelium from the cutaneous covering becoming invaginated and carrying in with it the ciliated epithelium belonging to the duct of Müller.

—PUERPERAL SEPTICÆMIA.—In the *Virginia Medical Monthly* of May, Dr. W. R. Cushing takes "A Skeptical View of some of the Reputed Causes of Puerperal Septicæmia." He attacks especially the theory of septic infection from without by means of *germs* arising from infectious or contagious diseases, such as scar-

let fever, diphtheria, erysipelas, etc. His arguments are as follows : "How the statement in regard to contagious diseases can be possible, and yet be in accordance with the nature of specific germs, is beyond my comprehension. The descriptive word, specific, in its definition, would prevent us from accepting, in the abstract, the idea that such germs or microbes can generate an affection different from that in which they originate. There can be no doubt that septic germs will produce septicaemia, and there must be, according to the germ theory of disease, a specific germ for its production that, in its nature, can cause no other. To arrive at any other conclusion amounts simply to assuming a thing as true and then hunting about for arguments to prove the position. The theory is stated as a fact ; but when called upon for proof, the writer or speaker argues as a reconciler, a trimmer, for and against, and when he concludes leaves us in the same state of uncertainty in which he found us. Take one statement made and follow it to a legitimate conclusion. A recognized writer says, 'Most authorities hold that true diphtheria of the vagina is not seen, only in some cases a diphtheroid mass may be found upon the vaginal walls, in puerperal septicaemia.' If this view be correct, we find that the so-called specific germs of diphtheria, which we have believed can cause nothing else, becomes wholly changed when transferred to the vagina of a puerperal woman, loses its specific character, and its whole nature is reversed ; so that it not only does not but cannot produce its own kind. Where will such theorizing lead us ? If the germs causing the various diseases can be so changed in their nature and effects, they are not specific, and the whole superstructure that the bacteriologists have been so industriously building threatens to fall about them. I will not discuss this any farther ; but admitting, for the sake of argument, the usually accepted belief, a question of importance arises that I do not remember having seen referred to.

"It has been emphatically stated that no practitioner should attend labor cases while he is engaged in treating any of the above-named diseases. One well determined point, learned not only from our own experience, but also from that of generations of physicians who have preceded us, is, that in the *majority* of contagious diseases, one attack protects the patient from a recurrence of it ; or, in other words, the specific germs have no effect whatever, after having once exhausted themselves upon the system. Of course, some exceptions occur, but they by no means disprove the rule. Take scarlet fever, as an example, acknowledged to be of this class. Is a woman in labor, who has had scarlet fever in childhood, liable to develop puerperal fever from being attended by a physician who is at that time treating cases of the former disease ? If she is not, it ought not to be over-looked ; on the other hand, indeed, every writer on the subject ought

to note the fact, so that the profession may fully understand it.

"To state the proposition more clearly, ought the scarlet fever germs have *any* effect in the case of a woman who would not be susceptible to them under ordinary circumstances? Reasoning from analogy, I would think not. An attack of smallpox protects from a recurrence of the disease, as a rule, without regard, to the manner of subsequent exposure. In other words, the virus of smallpox, whatever it may be, is considered as harmless as distilled water, to one who has experienced the disease, not even being an irritant. He may be inoculated with it, and the scarifications will heal like a simple cut without the virus. We are fast approaching the same belief in regard to some other diseases.

"The position I take is, that a person who has had scarlet fever, or other diseases that renders the system free from a second attack, will experience no effect in the event of a subsequent inoculation with the same virus. Pasteur's theory of the prevention of hydrophobia—the old system of smallpox inoculation, and later of vaccination, Ferran's cholera inoculations, and the yellow fever inoculations practiced in Brazil—are all based upon this idea. It is true that some of these things are still regarded as of doubtful efficacy, but the general principle is accepted.

"What have we, in the case supposed? A woman who has had scarlet fever, and is accordingly not susceptible to it, is inoculated with its germs, carried by the finger of the physician. What is the result? Under ordinary circumstances it would be harmless, and I fail to see why we should perceive any effect in such a case. Given a patient with such a history, I would be strongly inclined to attribute puerperal septicæmia to a coincidence and not to her contact with scarlet fever germs.

"The legitimate effect of this conclusion would be to modify professional opinion and teaching on this subject. If we admit that a woman can contract the disease through the medium of another affection, we can surely go no further than to say, no physician, while treating scarlet fever, and like contagious diseases, should attend a woman in labor who is not protected by having experienced the disease previously. I am anxious to draw out some opinions as to this question. If my reasoning is faulty, or if puerperal septicæmia will not be hemmed in by laws of analogy, I would like to know it."

—SOME PREVENTABLE CAUSES OF DISEASE AMONG WOMEN.—In a paper read before the meeting of the Medical Society of North Carolina, Dr. R. L. Payne remarked upon the want of care among parents, teachers, etc., in the management of young girls, and deprecated the lack of moral courage to resist the foolish fashions of society. Among the prominent preventable causes are impro-

prieties in dress, the bad habit of half-reclining upon the back with the feet elevated, the long continued use of the sewing-machine, too early marriage, the want of outdoor exercise, and the defective system of female education. He spoke of the foolish habit of clothing babies insufficiently, leaving too much of the body bare, or only partially covered, and even this of such thin material as to make the child liable to cold, and so seriously to retard its growth. He deprecated letting girls of ten or twelve years wear corsets, high-heeled shoes, and heavy underskirts tied around the waist—the natural result being interference with the normal functions of the thoracic, abdominal, and pelvic viscera. The present mode of covering the lower extremities exposes them to cold winds and dampness arising from the earth. Very many girls never wear any covering upon their lower extremities except underskirts and thin cotton drawers. Although he is not willing yet to see women wear breeches, he thinks their lower limbs should be protected by woollen garments of a character sufficient to protect them. He inveighed against the high-heeled, narrow-toed shoes worn by many women, declaring as the evil results of these shoes deformity of the toes and feet, and such displacement of the axis of the body in walking as to disturb the normal position of the pelvic viscera.

Inclement weather, or a want of proper accommodations, induced women to postpone an evacuation of the bowels and bladder until constipation, with its manifold evils, resulted. The unhealthy habit of sitting, half reclining, in chairs, with the feet elevated upon another chair or foot-stool, relaxes the muscles of the abdomen, throws the pelvis forward, and imposes the weight of the abdominal viscera, together with the pressure of corsets and underskirts, upon the organs in the pelvis. Of the sewing-machine, there was no doubt of this being a source of much disease among women—its immoderate use, rather than the danger of using a machine with some discretion, being the cause of trouble attributable to those otherwise useful articles of household furniture. He seriously objected to women entering into the married state at a very early age, believing that they can never safely undertake the duties of maternity until they have reached the age of twenty at least. Indoor life, sedentary habits, lack of fresh air, resulting in muscular weakness, a failure to make good blood and to permit proper digestion, are all conducive to the diseases of women. Of the education of woman, he thought the mistake of society consists in not recognizing, or, if recognized, not considering the destiny and noble purpose of becoming a good wife, a good mother, and a good friend. In the schools, girls are generally forced, according to the modern educational methods, without regard to the organic changes which are taking place, and the great need for monthly rest and the freedom from care required

to develop their productive natures. He quoted the supporting opinions of Clark, Anstie, Weir Mitchell, and Goodell. He does not desire to cut short the education of women, but he wishes to impress upon those engaged in imparting knowledge to the gentler sex the necessity for remembering the wide difference in her organs and those of boys; the necessity for more rest, more fresh air and outdoor exercise, and greater care in the regulation of her hygienic surroundings, particular attention being paid to the proper regulation of her catamenia.—*Virg. Med. Month.*

—**ARSENICUM IODIUM.**—The sexual group, as a matter of course, presents no symptoms in the provings, for it has not yet been proved by women: yet it is of great value, the annexed cases being witnesses. Dr. Gutteridge, speaking of scirrhus of the mammæ, remarks that "where enlargement is permanent, painless, and apparently stationary, calcium iodine is the medicine which should be administered; but where there is debility and manifest increase, the iodine of arsenic is to be substituted. And baptisia removes the fœtor, and relieves the cachexia, acting extremely well after iodine of arsenic, which, as an internal remedy, checks a tendency to ulceration, even where the skin is puckered and the auxiliary glands implicated."

Dr. Chapman reports the following case: "A young lady had a lump of considerable size in one of the mammæ; this and the other breast had wasted. She had taken iodine from the allopathic practitioners, in former years, in large quantities. The nipple of the affected breast was retracted; the tumor was very sensitive to the touch, and painful. She had a few doses of conium, and the cure was completed in about three months with iodine of arsenic of the 6th potency. The pulse in this case was very frequent; there was considerable emaciation; she was very easily fatigued from walking; and she had from a tender age been overworked as a governess. This young lady continues quite well."

Dr. L. B. Wells reported the following case of mammary scirrhus: "Mrs. B., æt 49. Sanguine temperament. At cessation of catamenia, had uterine and vaginal leucorrhœa, yellow, sanguinolent, with intense irritation of the parts, and a hard swelling of the labia, which had existed for several months. Lycop., sepia., calad., were given without any benefit. One year after, she had a swelling of a gland in the left axilla, size of a hen's egg, hard, and exuding a fluid which formed a hard brown crust. Tumor very sensitive and painful to touch. The breast of the same side enlarged, indurated and very sore. Gave ars. iod., 6th, morning and evening for one week, then every second day; both swellings disappeared entirely, as did also the swelling of the labia."

Dr. Williamson states that ars. iod. is of decided benefit in

cases of mammary and other forms of abscesses, characterized by the usual throbbing and great restlessness; and Dr. Julia Holmes Smith recommends it for chronic endometritis with thin, watery, bad-smelling discharge; the patient is liable to have sores. Hale originally proposed it as remedial in corrosive leucorrhœa with too frequent and profuse menses, generally with ulceration of the os.

Speaking of the use of this remedy in epithelial cancer, Dr. Ludlam remarks: "I usually prescribe it in the third decimal trituration, to be taken from one to four times during the day; and I really believe that through its employment some of my patients with epithelial cancer of the womb have been kept in a tolerably comfortable condition for months, and in a few cases for years, before the inevitable result has finally overtaken them."—*New England Med. Gaz.*

—ANTISEPTIC MIDWIFERY. Academy of Medicine, April 11, 1887.—But a few years ago the unfortunate woman who entered a hospital to undergo her confinement did so with one chance out of thirty or forty of losing her life. How great the change when it has become possible to say that "the woman confined there is safer than the one confined in her own home."

When we inquire what has brought about this happy result the answer is plain and unmistakable, the application of antiseptic principles in the management of these hospitals. In every instance in which this has been done intelligently and systematically, the reduction in sickness and mortality has been prompt and decided.

It is claimed by many that ordinary cleanliness in private obstetrical practice is quite sufficient. From the statistics given, we must conclude either that it is not, or that much of the midwifery practice of Cincinnati is decidedly unclean.

As the farmer would choose to keep the seeds of weeds out of his field rather than uproot them after they have begun to grow; as any one of us would prefer to escape the infection of typhoid by running the risks of aborting it when taken, so is asepsis to be preferred to antiseptis.

Failing in the former we have recourse to the latter.

The germs of the sepsis may be carried to the patient by the fingers or clothing of the attendants, by instruments. They are harbored by and multiply in decaying organic matter.

Cleanliness is the first and the great commandment of the antiseptic code.

Whenever practicable the physician should see that the lying-in apartment is light and well ventilated; that it has not been recently occupied by any zymotic disease; that it does not contain a stationary washstand.

In the homes of the poor we of course have no choice, and it is one of the advantages of Dr. Garrigues' method that it can be carried out in the humblest homes and affords protection against infection even in unfavorable surroundings.

He orders if possible the patient to take a full warm bath at the beginning of labor.

Give an enema of a quart of soap suds.

Have half an ounce of bichloride of mercury divided in sixteen powders.

Pour one powder into a quart bottle, add a little hot water, shake, add alternately cold and hot water till the bottle is full. Shake well. This is the standard solution of 1 in 1000.

Scrub your hands, and for operative interference your arms, with soap and water, using a stiff nail brush, and then scrub them again with solution. Use special care for the space under the nails at their root. Clean your nails with a pocket knife.

Place beside the patient's bed a basin with solution (1:2000) in which you hold your hand, and any thing which comes in contact with her genitals for at least one minute upon touching her.

Wash the patient's abdomen, buttocks, thighs and genitals with solution (1:2000), and if she is not clean scrub the parts first with soap and water. Inject a quart of the same solution into the vagina.

Use no lubricant, except when the whole hand has to be introduced. Then use carbolized glycerine—three per cent.

Examine rarely, and do not introduce your finger inside the os in common cases. When the presenting part begins to open the vulva, cover it with a compress wrung out in solution (1:2000). Likewise after the child is born. If after delivery it has been necessary to introduce your fingers into the vagina, or if during delivery manipulations have been performed in this duct, inject from a pint to a quart of solution (1:2000).

If fingers, hands or instruments have been introduced into the cavity of the womb, or if the child is macerated, give an intra-uterine injection of two to three pints of hot solution (1:4000) Wash the patient with solution (1:2000).

Put on a belly-binder and antiseptic occlusion dressing.

Change the dressing every six hours in hospital practice or every three hours in private practice. Let the patient at time of changing use the bed-pan, and after that run a stream of luke-warm solution over her genitals and surrounding parts. No vaginal injections in normal cases.

Disinfect instruments with a solution of carbolic acid (5 per cent.) If a lubricant is called for, smear with carbolized glycerine—3 per cent."

Discussion.—Dr. Zinke. The questions at issue simply are :

1. To what extent, and in what manner, should antiseptics be carried out?

2. Which antiseptic drug is the best to prevent the formation, accumulation, or proliferation of the septic material, and is at the same time, free from danger to the mother?

To determine this, it is necessary to consult, not only our own, but the collective experience of the professional world. And we find:

[A] Not one of the germicides employed for this purpose, is used in such potency as to produce the death of any germ in a short time. If they were, injury would be inflicted upon the women.

[B] Bichloride of mercury solution (1:8000) is looked upon by many as the only sure and reliable antiseptic, but all admit, that carbolic acid, permanganate of potash, etc., will answer as well; and that the vital principle of antiseptics in all respects, is simply cleanliness and intelligent care.

Should we employ vaginal and uterine injections as a precautionary measure after every delivery? I answer emphatically, no! Does the necessity of washing out the genital tract, the uterine cavity included, ever arise? Yes! Vaginal irrigations are never indicated in the healthy woman, in normal labor, nor thereafter, as long as the lochia remains pure, and as long as there exists no rise in temperature, nor pains in the pelvic region, other than those due to normal uterine contractions. They should, as a precautionary measure, be employed when labor has been protracted and severe, providing the obstetric canal has sustained injuries such as lacerations, contusions or excoriations. They should be especially resorted to in cases where it is necessary to introduce the hand frequently, or when instruments were employed to effect the delivery of the child. Uterine irrigations immediately after the completion of labor or during confinement are rarely called for, and should never be resorted to, except in cases of the most urgent necessity, and that is, when it is observed that marked and severe symptoms of septic infection (which cannot be controlled by vaginal irrigations) is imminent, and when all other means usually employed fail, and there is a suspicion that portions of the secundines have remained within the womb. In such a case, and in such a case only, can I see any justification for their employment.

The correspondent at Vienna to the *Jour. Am. Med. Ass.* states "that these splendid results are not to be attributed to the excessive practice of some eminent practitioners that would enforce uterine and vaginal irritation of an antiseptic fluid, even in cases of normal labor, but the elaborate cleansing of arms, hands and nails before an examination is made. Attention to attire, so that the obstetrician should not wear in the lying-in room the same coat which has followed him in his many daily calls. The practice

of this school speaks volumes and meets, for so it seems to me, every indication of exactness, without being meddlesome."

Dr. Gibbons reported in 1882 to the San Francisco Obstetrical Society a case of primipara, who had an easy forceps delivery, resulting only in a slight laceration of the perineum. There was also a slight hemorrhoidal difficulty complicating the case; although it appears that this yielded to treatment. Vaginal injections had been ordered. On the morning of the tenth day, Dr. Gibbons found his patient perfectly well, and in a happy state of mind. At noon he was hurriedly called and found the patient dead. While in the act of giving an injection, the nurse noticed her countenance and thought she had fainted. There was no pain, as she expired without a groan.

At the International Medical Congress Copenhagen, August, 1884, Breisky of Prague expressed himself as opposed to the practice of prophylactic intra-uterine injection post-partum. He avoids them as a rule, and admits them only on definite indications. The results of the Paris Maternité as described by Bounaire, are brilliant, but thus far they extend over but one term. Breisky has equally good results for some years with limitation of the intra-uterine injections in its principal

Dr. D. B. Simmons reports a case which occurred in a woman not in the lying-in state. Almost immediately after having used the injection, she experienced great pain in the lower abdomen, a feeling of indescribable distress "all over," and a sense of suffocation. These lasted in varying degrees for about an hour when they gradually passed off, excepting a pain in the lower part of the back and loins at short intervals which continued for some time longer. The next day, however, nothing remained of the difficulty experienced except some tenderness over the uterine region.

Dr. John Cleveland, reported a case in which death occurred 24 hours after the use of a vaginal warm water injection. The patient was apparently doing well, and the injection was employed simply from a sense of duty on the part of the doctor. Almost immediately after the injection was made a severe pain supervened, and could not be subdued even by repeated injections of morphia. The abdomen became tympanitic, the temperature rose to 104° in the evening and increased to 108 the next morning. The patient died, notwithstanding all the efforts that were made to save her life.

In my own practice I have had to record three cases in which severe uterine colic ensued almost immediately after the irrigation had been made. In each instance they had been carried out with great care and a Fountain syringe, used twice by myself and once by a competent nurse.

The argument that all these ill-effects attributed to vaginal in-

jections are due to awkwardness and want of care, may be true in some instances, but not in all, unless it be admitted that the great mass of medical men are stupid, awkward or negligent. Even granting this were so (which I am inclined to doubt), all the more should they not be permitted to employ these injections unnecessarily and indiscriminately.

The latest invention seems to be the so called "antiseptic pad;" it, too, like vaginal irrigations in every labor case, deserves the severest condemnation, because equally unnecessary, if not fully as harmful. Of late we have been made acquainted with the sad fact that the mortality rate is shockingly high in some of the public hospitals of this country, viz: Louisville City Hospital 3.75 per cent. of the women confined. Indianapolis City Hospital 4.71, Kings County, 4.76, Brooklyn Maternity, 4.44, New Orleans Charity, 10.22 per cent.

This would seem to point to a reckless disregard of antiseptic midwifery. All I have to say is that these institutions should be called upon to explain, for unless they do so, we are left to imagine that either they carried the use of antiseptic midwifery to an extreme, or that they neglected it altogether.

Dr. Giles S. Mitchel said he had not the same confidence in the protective power of healthy lochia as had been expressed by several members. He called attention to the experiments of d'Espine, who demonstrated that lochia from a healthy woman on the third day would kill a rabbit.

He regarded the hygiene of pregnancy of primary importance, although a physiological process, utero gestation induces important functional disturbances. The blood was increased in quantity but vitiated in quality. Additional tasks were imposed upon the lungs, kidneys and other viscera. Reflex derangements of the nervous system and digestive tube were of frequent occurrence. An increased amount of carbonic acid was eliminated by the lungs, hence the necessity for fresh air.

Frequent bathing and flannel underwear kept the skin healthy and protected against sudden changes of temperature. The food should be simple and nutritious. Tight clothing was to be forbidden. Where there existed a specific taint, anti-syphilitic remedies should be employed. A rheumatic diathesis required proper treatment. Chronic malarial poisoning demanded the administration of quinine. Speaker regarded that proper attention to the above was of even greater prophylactic utility than the occlusion bandage of Garrigues or antiseptic vaginal injections.

He recognized the timely application of the forceps and the judicious administration of chloroform in tedious labors as also a prophylactic measure of great value. The exhaustion of nerve-force and muscular energy on the part of the mother in fruitless efforts to expel her offspring, retarded involution and

left a gateway open for the entrance of germs.—*Cin. Lancet Clinic.*

ETIOLOGY AND PROPHYLAXIS OF OPHTHALMO-BLENORRHEA IN NEW-BORN INFANTS. (*Arch. f. Kinderh.*)—Dr. Haab warmly commends the prophylactic treatment of Credé in new-born infants (viz., a drop of a five per cent. solution of nitrate of silver instilled into each eye as soon as possible after birth). He thinks that the use of this substance is to be approved not only as a prophylactic, but also as a customary means of treatment for purulent connective tissue inflammations, in this respect being far preferable to resorcin, chloride water, carbolic acid, salicylic acid, sublimate, benzoate of soda, etc. The favorable results of the use of argentic nitrate as a prophylactic is seen in statistical compilations. Before the employment of Credé's method seven to nine per cent. of children suffered from inflammations of the eye. Since that method has been in use only one per cent. have thus suffered. According to the author's opinion true *blenorrrhea neonatorum* can only take place by means of gonorrheal infection at the time of birth; simple lochial secretion, or simple *fluor albus* never giving rise to this condition. The only positive proof, under whatever circumstances, that blenorrrhea exists, and not catarrh of connective tissue origin, is the demonstration by the microscope of gonococci in the secretions. The author expresses the opinion that since the use of the nitrate of silver will prevent the development of catarrh of the connective tissue, as well as that of blenorrrhea, its use will not meet with objection on the part of parents who might be sensitive to the imputation that there was a possibility of the latter disease.

—CHRONIC CONSTIPATION AND ITS GRADUAL CURE.—People who suffer from chronic constipation are also those who constantly use purgatives and nobody can tell beforehand what the action will be on the patient. We see such people constantly changing their purgatives and increasing their doses, till finally they are forced to take their refuge in clysmata, which are no less injurious, using several of them in succession, in addition to their regular purging doses. In only one case clysmata shows less injurious effects and may be even allowed with benefit, and that is in constipation during pregnancy, but the exception only proves the validity of the rule.

Itching of the female genitalia and anus is also a not unfrequent sequence of this abuse, especially after drugs which also produce passive congestion in the pelvic organs. Hence *hemorrhoids* in both sexes often originate from the same abuse, often bleeding and very painful, and the more drugs are taken to ease the passage of the fæces, the more the knobs sometimes increase in size.

The pressure downwards to force a stool often also causes *proidentia of the uterus*, and we may expect such an effect more surely when there is already chronic or inflammatory state of one or both ligaments and in consequence thereof their elasticity and power of resistance lessened. Just such cases are usually combined with obstinate chronic constipation and still the necessity of pressure is too often not obviated by purgantia nor by a combination of both. Still more disagreeable it is for such women when constipation and leucorrhœa coexist, as the latter increases when the bowels do not move regularly.

Chronic constipation, against which purgantia and clysmata are steadily used, leads in young girls to *redness and painfulness of the genitalia, or also to fluor albus*. Finally, let me mention a point, more of a psychical nature, that the daily use of purgantia, and still more of enemata, is very apt to render *women, and especially young girls, nervous and irritable*, and I feel assured that thus a *neuropathic disposition* is formed, on the basis of which it needs only a small impulse to cause neuralgiæ of sympathetic or spinal nature, undermining nutrition and tissue change. Such neuralgiæ of the intestinal canal produce insomnia, deep melancholia with the delusions that they have snakes inside which torment them by their irregular motions, that rape had been committed, and suicidal notions arise in their minds. Neuralgiæ of the bladder and vagina, clavus hystericus are frequent manifestations, and when inquiring more closely into the history of such cases, we learn of the constantly increasing daily dose of purgantia, of daily repeated injections and still more of painful and unsatisfactory discharge of fæcal masses.

In all such cases, from whatever cause they may have originated, a *strict diet is the sine qua non* of successful treatment. Of solid food I exclude bread, vegetables and potatoes. All pastry is interdicted and confectionery must not be thought of. Live on fruit, fresh or stewed, fresh meats, not too fat; eggs, fish, a little cheese, are the staple articles for such people. If the patient likes his food well-seasoned, there is no objection to it. Of fluids, we interdict milk, red wines, cider, alcoholics, gruels. We allow coffee, which in such cases is even not injurious to nervous women, tea, beer, chocolate, beef-tea, white wines. During the first week of treatment the patient complains of the severity of such diet, but becomes used to it during the second week.

Our external treatment is of equal importance. In lighter cases daily massage of the abdomen with balsam. vit. hoffmanni, three times a day may suffice, or in some cases, twice daily, rapid brushing of the abdomen with equal parts of oleum hyoscyami and chloroform, immediately covered with rubber-paper, to which in still more obstinate cases dry hot poultices of sand or salt may be added. Such a constant heat is often of the greatest benefit.

During the whole treatment heavy flannel bandages ought to be worn around the abdomen.

The time of this cure oscillates between one week to four or even six. Gradually the restrictions may be removed and after several stools passed without artificial aid some bread may be allowed, then some vegetables or some milk.

In relation to the whole treatment, we advise :

The patient after having had an artificial stool that day, begins his dietary treatment. It is well to tell him that no stool will probably follow during several days ; and if his customary headache sets in, a diminished dose of his usual purgans may be allowed. With our diet the quantity of fæces diminishes and therefore not so much heaviness or pressure will be observed.

I felt astonished that so many married women, suffering from this chronic constipation were sterile.

We all know the value of treatment by rest. Only thus we allow rest and ease to the intestinal canal ; all inflammatory manifestations are overcome ; the exhausted peristalsis is removed and the natural functions re-established.

It is a curious fact that Vogel and Henoch in their works on infantile diseases interdict the use of milk in intestinal catarrhs of children, and now we are inclined to agree with these authorities, as condensed milk certainly clogs up the intestinal tube, and thus produces a stagnation leading to a loss of peristalsis.

On the other hand, in an irritable state of the bowels, as we find in both forms of cholera infantum, condensed milk or other forms can only be considered as a farther noxa, and increasing the irritation.

Alas ! That a mother nursing her baby is considered unfashionable ; and even where, once in a while, a conscience-stricken mother tries to fulfil her noble duty, her whole bringing up was such as to render her unfit to the task, and failure follows. A wet nurse is to me an abomination, though the origin of wet nurses dates from antiquity. She is a trial which has to be submitted to by the whole household for the benefit of the little ruling angel, though its ruling is too often rather tyrannical.

Dr. Gehrman also raises his voice against the habitual use of farinaceous food for little children, and we see the justice of this prohibition, as we know from experience that *alumina* has stood the test of time in infantile constipation. Its chief indication is this abuse of farinaceous food, long standing cases which resisted other treatment, a want of action in the colon and rectum so that even a soft stool needs great effort, often followed by faintness and chilliness after stool. We find the same depraved and imperfect digestion under *Lycopodium*, with a constant sensation that the bowels are loaded, flatulent colic, fæces hard, scanty, passed with

difficulty, hence in children crying before and after stools, as well as before and after urinating, and either drug may fail if we fail to change the diet and give it food suitable to its constitution and personality.

But we may fail in another direction, and give the child animal (meat) food at too early an age. Here, with a carefully changed diet, we have a splendid remedy in *nux vomica*, even in children, who, naturally of a kind disposition, become morose and irritable by the burden put upon their tender muscles. In such cases of obstinate constipation in infants, we often wavered between graphites and sulphur, as here the symptoms are very much alike, but just here throw aside these every day symptoms and look out for the key-note which characterizes the case and the remedy. Thus we read of infantile constipation under causticum, but we find here a nervous child, afraid of darkness and of solitude, in larger children enuresis nocturna, and the stool may pass when the child only expects some flatus; fear predominates in the nature of the child.

Kreosote is one of our best remedies for the ailments of dentition and where marasmus threatens, it may save the life of the little one whether it suffers from constipation or diarrhoea, as both may be the output of a loss of peristalsis. We several times succeeded in curing unpromising cases of gastromalacia in children with kreosote after the failure of other apparently indicated remedies.

Hughes considers *hyarastis can.* one of the chief remedies for habitual constipation, and it acts well in cases produced by the frequent use of aperients, or when caused from sedentary habits. We see that in its causes the golden seal resembles *nux vomica*, but it differs from it in that the latter has irregular and even antiperistaltic action of the bowels with ineffectual desire for stool, and even after the stool passed there is a sensation in the rectum as if there remained much to be passed, whereas in *hydrastis* no need, no desire for stool, or a sensation as if the bowels would move, but only flatus passes, and our hypochondriac patient considers the constipation the cause of all his other ailments.

That habitual constipation is found under *collinsonia*, a favorite drug with us in women, especially during pregnancy, or in connection with uterine disorders from pelvic congestion, hence extreme tenderness in rectum, backache and hipache, bleeding piles from constant straining at stool.

The constant backache, especially in hip and sacrum, is also found in *æsculus hip.*, with great fatigue in walking, and is one of our chief indications in intense disorders as well as in chronic constipation with sensation in rectum as if full of small sticks, but notwithstanding the throbbing in the abdominal and pelvic cavities we meet with very little bleeding, so pronounced in

collinsonia, and only in a lesser degree in *nux vomica*. Dryness of the mucous membranes is characteristic of the horse-chestnut.—*Hahn. Monthly.*

—UTERINE DISEASE IN ITS RELATION TO EYE DISEASES.—Dr. F. R. Pooley, of New York, has written a paper on this subject, and summarizes as follows :

1. In certain cases there is a direct relation between irregularities in function and diseases and concomitant affections of the eyes.
2. The eye affection may be merely functional, or there may be organic disease.
3. Asthenopia exists in cases where there is ametropia, apparently due only to the reflex effects of the uterine disturbance on the organs of vision.
4. In many of these cases there is paresis of accommodation.
5. In other cases of asthenopia in which ametropia is present, and the existence of uterine disease as well, the former is not always relieved by correcting glasses.
6. Other functional anomalies than asthenopia may be observed, such as blepharospasm, diplopia, and functional irritation of the retina.
7. Long-continued reflex irritation from uterine disease may result not only in asthenopia, but as already shown by Mooren, in atrophy of the optic nerve and other organic changes.
8. Irregularity of circulation and venous hyperemia about the climacteric period may be the cause of intraocular hæmorrhages.
9. Loss of blood from uterine hemorrhage affects the nutrition of the optic nerve and retina, leading to dangerous results.
10. A variety of pathological conditions of the uterus may be responsible for the eye troubles, but they may occur more often where the disease is of a chronic nature, as in displacements, lacerations of the cervix, and other affections accompanied by congestion, and the nature of the disease is such as to effect the normal process of menstruation.
11. The proper therapeutic measures to be adopted in such cases are : the rational treatment of the uterine disease ; the correction of any existing ametropia ; the temporary use of weak convex glasses when there is feebleness of accommodation. In some instances galvanism for the relief of supra-orbital neuralgia, proper food, and favorable hygienic conditions.

USE OF TAMPONS IN TREATMENT.—Tampons are applied to the vaginal wall or into its cavity for various therapeutic purposes, viz : (1) *For retention.* When the cervix has been incised or when other operations were performed upon the uterus and it is necessary to fix bandages or remedial applications to any intravaginal

structures and to there maintain them, or when intrauterine pessaries, tents of any kind, are to be kept for any time in the cavity of that organ. Also when the uterus is to be fixed in one place, for instance, after reposition of a displacement, etc. Such tampons are placed either in the anterior or posterior portions of the cavity. (2) *As protective.* When ulcerations, erosions, or other wounds exist in the structure inside the vagina, chafing of the wounded surfaces is prevented by application of a covered tampon, also to guard healthy tissues against the corrosive action of some secretions, etc. (3) *As a means of pressure* a tampon is employed in uterine hæmorrhage, also to keep the walls from approaching after dilatation of the vagina or the cervix. In cases of hæmorrhage, the tampon should be applied directly, if possible, to the bleeding surface. (4) *To fix and maintain in place* balls of cotton or sponges saturated with some remedial liquids. (5) *A tampon is sometimes used for diagnostic purposes* to ascertain the nature of the secretion oozing from a lesioned structure, by allowing the ball of cotton or sponge to become saturated with it after staying some time in the cavity. Absorbent cotton is the most useful material for tampons. A variety of prepared cotton is now in the market for all sorts of applications; salicylated, boric, disinfected, etc. The shape of tampon must necessarily vary according to the requirements of the case. A number of gauzes saturated with some medicinal or antiseptic substances, also several varieties of textile fabrics and other substances, saturated or not with therapeutic agencies, are now in vogue for every class of tampon made. Introduction of tampons can be made either through the speculum or without it. A forceps is mostly necessary for its introduction into the cervical cavity or very high up in the vagina. When the tampon is wholly or in part saturated with corrosive or very astringent liquids, it is best to use a wide cylindrical glass speculum to protect the healthy tissues from injurious effects of the corrosive. It is also sometimes sufficient to introduce the tampon as far as the cervix through the speculum and then with the fingers push it directly into the cavity. A good forceps with broad blades is usually sufficient to hold the tampon during its introduction into the cavity. Sims, Braun, and Weisel have invented special instruments for that purpose. Sims' instrument, improved by Braun, consists of a capsule forming the point of a curved tube corresponding to the pelvic axis. Into this is inserted an equally curved rod, provided at the capsular extremity with a disc, which pushes the tampon placed in the tube forward. There are other more complicated tampon-holders, but they offer no particular advantage over this simple contrivance. Tampons of very large size are sometimes used to press upon the vaginal walls to produce their contraction. Simple cotton tampons ought never to stay longer than twelve hours within the cavity, otherwise

they will become imbibed with other decomposing secretions and often produce infection or other injuries. It is always best to use a strong thread to wrap them, for a weak one readily breaks and leaves a portion of the tampon behind. Glycerine solutions of remedies to be used with the tampon are most useful, since glycerine forms an excellent solvent of many remedial substances and acts also as an antiseptic upon the cavity walls. They also assist in absorbing a great deal of over-secreted mucus. Before the introduction of a tampon all secretion should be removed by irrigation with tepid, warm, or cold water, as the case may require. The same should be done after removal of the tampon. Disinfectants should always be used. Tampons are often very useful to collect secretions from the uterus for examination. For this purpose, after cleaning the vaginal cavity and wiping off any secretion adherent to the cervix, the cavity is dilated with cotton and a flat cotton tampon saturated with fifteen to twenty per cent. solution of glycerine and tannin is introduced and fixed upon the cervix with the speculum. A number of other tampons are further introduced until the walls contract and thus hold the tampons well fixed. The next day the tampons are removed, the last introduced first, and finally the tampon on the cervix. Upon this will be found a small quantity of the secretion collected on the external os. This is removed and used for examination. The use of tampons in the uterine cavity, although recommended by high gynaecological authority, is of doubtful value; it is readily supplanted by many easier and safer surgical operations. Only when the cavity is very wide and thus readily admits tampons of any size, as is the case in large fibromata or polypus of the uterus, and there is severe hæmorrhage, are tampons of any actual service. For the purpose of dilatation of the cervical cavity they are inferior to sponges or laminaria tents.

J. A. JEANCON, M.D.

—PSOAS ABSCESS: WHEN AND HOW TO EVACUATE IT.—Edmund Owen, *Br. Med. Jour.*—In the surgery of childhood there is probably no branch of practice which has derived such beneficial influence from the principles of antiseptic surgery as the treatment of psoas abscess.

So far as my experience serves, twenty years ago most cases of psoas abscess went wrong under active treatment, and surgeons were shy of interfering with them; dealing with them in a half-hearted and apprehensive way, they dreaded the almost inevitable hectic fever and gradual and fatal exhaustion.

When using the words "antiseptic surgery," I do not mean to imply that everything in the way of improvement is due to the spray and gauze. I refer to no narrow ritual, but to the grand principles of modern surgery, whether practiced by Lister or Tait.

For now that the spray has, in every sense of the word, cooled down, and the atmosphere of surgical practice and criticism is less obscured by clouds of carbolic vapor, one is able to take a much wider and more liberal view of the entire question.

Twenty years ago, if the surgeon could do so, he preferred leaving a psoas abscess alone; but if the collection of matter were bulging to such an extent as to cause a reddening and thinning of the skin; if, in short, Nature were forcing his hand, he would perhaps thrust into the abscess a canula and trocar, or partially evacuate it by a valvular opening.

It was at about this period that Holmes wrote that his experience led him to dissuade the opening of abscesses which were associated with spinal disease; that however effected, and with whatever precautions, it generally did more harm than good. And Alex. Shaw also spoke about "hesitation and delay," and held the somewhat vain hope that the surgeon might possibly succeed in dispersing the collection by resolution.

The chief reason or excuse for adopting the Fabian policy was that possibly the abscess might remain quiescent for all time, or that it might happily disappear altogether. Thus, in 1849, in his classical *Treatise on Diseases of the Bones*, Stanley wrote:

"The knowledge of the fact that even in a small proportion of cases a psoas abscess has been observed to undergo no change prejudicial to the part, or to the health of the individual, furnishes a ground for not interfering with the abscess; but another and still better reason for abstaining from such interference is that the disappearance of the abscess may take place by the absorption of its contents." He goes on to say that the opinion has been expressed on good authority that this natural cure of a psoas abscess never occurs, but that, nevertheless, he is sure of the fact, and that he is thus brought irresistibly to the conclusion that a psoas abscess should not be opened until it is about to burst.

One of the points on which I would specially ask for an expression of opinion by modern surgeons is whether psoas abscess does often undergo this spontaneous cure. In my own experience the contingency has been so rare that I do not consider it as within the range of practical therapeutics. My invariable experience—with one exception—is that when in connection with a stiffened spine, an ovoid or fusiform tumor can be detected ascending in the depths of the iliac fossa, it is only a question of time as to when its purulent contents reach the surface. For their removal aspiration is of no value. The tubular needle is quickly choked, and flakes of fibrine, shreds of ruined intervertebral discs, and fragmentary sequestra of the vertebræ can never be removed by it. The abscess quickly fills again, and within a few days of making the attempt sero-purulent fluid leaks through the puncture, and unless thorough evacuation be at once performed, the abscess

runs great risks of becoming septic. Irresolute attack of any other kind gives an equally unsatisfactory result. All this being admitted, there is no alternative for the practical surgeon but freely to open and drain the abscess.

The method of evacuating psoas abscess, which I have adopted in a large number of cases, and which I recommend with confidence, is by a free anterior as well as posterior opening, and by then washing and draining the cavity right through. The first opening I make close above the outer end of Poupart's ligament, using the scalpel until about an inch of the length of the fibres of the aponeurosis of the external oblique has been exposed. I then scratch through the fleshy attachment of the internal oblique and transversalis, and, keeping well below the level of the peritoneum, thrust the director into the swelling. Pus escapes, and the opening is enlarged by the dressing forceps and the finger. A stiff probe is then passed through the abscess cavity and made to project beneath the skin on the outer side of the erector spinæ. With this as a guide, a counter-opening is made in the loin. The large cavity is then flushed perfectly clean with a warm antiseptic solution, and a drainage-tube of the size of a penholder is laid through the chasm for a few days, being afterward replaced by a silk thread. The parts are liberally covered with bulky pads of wood-wool and finely picked oakum in gauze bags; these are kept in position by a towel arranged as a binder, which, for the sake of compression, is tightly drawn and fixed with safety pins. Next day the cavity is again washed out, under chloroform, if necessary, the wounds being dressed as before. After this, the less that it is interfered with the better; if the temperature do not rise, and the discharge do not soak through, the dressings may be left for three or four days, or longer. From the first day the discharge becomes thin and watery, suppuration in the ordinary sense of the word is at an end, and the cavity steadily contracts into a narrow passage.

If the abscess be so small that the surgeon does not feel inclined to attack it in front, he may readily work down on to it above the iliac crest, on the outer side of the erector spinæ. The scalpel is needed only for the skin incision, the rest of the operation being performed with equal ease and safety by the use of a steel director and the ring-dressing forceps—at any rate in children.

Of the evacuation of unilateral psoas abscess, after the manner recorded, I have had a large number of examples, and it so happens that we have lately had under treatment in the ward, at the same time, three cases of double psoas abscess, each of which is deserving of special record.

The first is that of a girl, aged 6, who was admitted last March; she was pale and thin and had been losing power in her lower limbs for about a year. A large psoas abscess reached from below each crural arch to the carious lumbar vertebræ. Mr. Lewis, the

house-surgeon, evacuated the left abscess of one side only, fearing lest the simultaneous attack of the two abscesses should cause serious shock. The child did not do well and the temperature rose. At an interval of a week or two the other side was washed out and drained, and immediately the temperature dropped toward normal and has not materially raised since. The child is now at the Convalescent Home of Children's Hospital, greatly improved in every way.

Another girl, aged 6, had a right psoas abscess evacuated in May last: her temperature remained normal for about two months, when it began to ascend two or three degrees at night, and the child complained of much pain. Examination showed that the left side was occupied by an abscess, which had filled quickly. This I opened, front and back, thoroughly flushing the cavity with a warm sublimate solution (1 in 1,000); it was noticed that some of the injections returned by the opening on the other side. I much regret to say that this poor child died within four hours of the operation, death being preceded by three attacks of vomiting, and by collapse; she had, moreover, several loose motions, and the urine which was passed just before death was bloody. Of course the vomiting might have been due to the chloroform; but when this feature is considered in conjunction with the persistent and fatal collapse, the loose motions, and the hæmaturia, the circumstantial evidence, in favor of her having been brought under the toxic effects of the sublimate salt, is strong indeed. At any rate for the future, I shall discard the mercuric solution of the strength of 1 in 1,000 for washing a large cavity in a child, and shall revert to warm iodine-water, decolorized, a solution of which I have great reasons to speak highly. (Salivation would not be expected in the case of sudden mercurial poisoning).

The third case is that of Rebecca L., aged $5\frac{1}{4}$, who, twelve months previously, had been treated at another hospital for spinal caries. On admission to Great Ormond Street, she had a large psoas abscess on each side, which had been noticed for eight months or so. On July 12th, 1886, the surface of the body having been cleansed, each abscess was opened, front and back, and drained. Since then she has been steadily improving in every way, and is getting fatter. As is shown by the chart, her temperature has remained steadily against the normal line; it has never reached 100° F.

Conclusions.—It is impractical to look forward to the spontaneous absorption of a psoas abscess; sooner or later it must be evacuated by Nature or art. In this matter art has the advantage, as by her aid the cavity can be at once emptied, cleansed and drained. The earlier the abscess is opened the better; for delay may entail the extravasation of pus, and the formation of a needlessly large and intractable cavity. The abscess should be opened

and irrigated from the front and drained through a counter-opening in the loin. Washings and drainage should be thorough, for a small abscess a single opening at the back may suffice.

Warm iodine-water (decolorized) is the most suitable fluid for irrigation; the sublimate solution (1 in 1,000) is dangerous, at any rate in a large or double psoas abscess in childhood. The most convenient dressings are bulky pads of wood-wool and gauze bags of finely packed oakum; they should be fixed under a towel tightly pinned as a binder. Pus may rapidly collect on the opposite side of the spine, after a single abscess on the one side has been evacuated; therefore, if the temperature rise and remain high after the evacuation of a unilateral abscess, the formation of a second abscess should be watched for, and it should be opened as soon as it is detected; thus convalescence may be at once established.

Bilateral abscesses should be attacked simultaneously; they are likely to be in intercommunication, and the area of suppuration cannot be kept aseptic unless both sides are washed and drained.

—CORRESPONDENCE FROM EGYPT.—We clip the following from a letter: At about the age of four years the boys and girls are circumcised. In the case of the girls it is the labia majora, along with the clitoris, that are cut off, but very often this rite is neglected in the female.

There used to be a lying-in hospital at Qasr-el-Ainy, where poor women are admitted and had their confinement conducted free of charge. This hospital afforded ample opportunities for ingratiating the neophyte midwives into the practical mysteries of their art, while it was a good boon to many a poor native woman.

In treatment of native women, one has to be patient and wait for opportunities of thoroughly examining them, so as not to bump up against their prudery. In hareem practice we must make haste slowly.

Thousands of criminal abortions are perpetrated by midwives. The shameless way in which native women ask respectable medical men to perform this "small operation" for them is only a sign of how commonly it is practised among them.

—BOOK REVIEWS.—One of the most embarrassing positions for an editor to fill in conducting a medical journal is that department assigned for the purpose of reviews of medical work after they leave the publishers. If the editor be a candid and honest critic, of the various books placed at his command for inspection, his subscribers have a decided advantage in making a selection. If on the contrary the editor caters to the publisher for the sake of

receiving books to swell his personal library and always makes it a point to give a good report regardless of the merit of the work, his readers suffer not only in money but in their confidence in the judgment and opinion of the journal and editor, and thereafter look askance at the reports as they may appear. If he reviews the work as its pages represent : coloring no chapter ; giving praise where it is due ; condemning that part which deserves censure ; noting all errors ; in fact permitting those of his subscribers who are relying upon him to have a true picture of the contents of the work ; he will obtain the thanks of a grateful profession. If, however, to avoid the ill-will of the publisher, he deceives his subscribers in regard to the true merits of the work he should receive the severe censure of all.

We review all medical works for the interest and information of our readers, not the publishers, and with this view they may depend upon a fair and ungarnished review, so far as our judgment goes, and we desire to announce that we shall express our opinion at all times, as to the true character and value of every medical work placed in our hands for review, regardless of the publishers or whether the book was purchased or presented to the journal for "notice."

AMERICAN INSTITUTE OF HOMŒOPATHY.

Sectional meetings of the American Institute at this day have ceased to be experimental in character, and henceforth the principal interest in this national body will be centered in the reports of the various bureaus. The day and time has passed for large, unwieldy bodies, numbering hundreds, like the institute, to report in general session and expect the papers and subjects for discussion to be thoroughly presented and digested. This year's meeting fully demonstrated the fallacy of adhering to the old routine practice, and the deep interest manifested in the different sectional meetings endorsed the wisdom of the scheme originated by Prof. Ludlam for separate meetings of bureaus. The large and enthusiastic meeting of the Bureau of Gynæcology this year was not only flattering to its special officers and members, but showed conclusively that the institute was ripe for a change in bureau reports and ready to cast off its swaddling clothes, and, hereafter, all laws made governing any bureau work must be in direction of sectional meetings. The character of the reports of the bureaus of obstetrics, gynæcology, and pædology this year were of a superior order and deserved the acknowledgment they received at the hands of the members of the institute. The report of Dr. George Peck, of Providence, was well worth special mention, as it covered a

vast field of usefulness in the branch of obstetrics and displayed the feeling of the profession-at-large, as the report was statistical in character. The president of the institute showed his appreciation of Dr. Peck's work by appointing, regardless of rotation or set rules, him chairman for the ensuing year. Truly, some of us are not forgotten in the distribution of prizes at the end of the year for labor performed. Dr. C. D. Crank, of Cincinnati, as chairman of the Bureau of Pædology, made one of the most interesting and intelligent reports we have ever had the pleasure to listen to. His report fully demonstrated the value of ex-President Runnell's advice in his annual address, that in selecting chairmen of the different bureaus those members should be appointed who are known and recognized for their special standing in the respective departments to which they have been chosen. By this means the institute is sure of reports superior in order and interest. "Skin Diseases of Infancy and Early Childhood," could not but prove an instructive subject, and all who had the pleasure of listening could not but feel well paid for attending the meeting. If there is any one disease in childhood more than another which proves intractable to our remedies, we have it to meet. In our hands it has truly been a "stumbling-block" for many years. The printed transactions of the institute for 1887 will be examined with unusual care for the purpose of making ourselves familiar with the literature of "Skin Diseases of Infancy and Early Childhood." With the report of the Bureau of Gynæcology what can be said except in praise? Commencing with Dr. Edward Blake's paper on "Cervical Dilatation as a Curative Measure," Dr. Ludlam followed with a practical "talk" on "Hot Water as a Topical Application in the Various Uterine Disorders." If any one member of the bureau could make "hot water" interesting, it would be Dr. Ludlam. In his hands the subject proved anything but a "dry" one and demonstrated the author's ability to teach gynæcology in a manner that would "stick" in spite of the large quantity of "hot water" he used in his report. "Intra-uterine Medication," by Dr. L. A. Phillips, of Boston, was a scholarly address and is well worthy of a place in our standard works of the day. By persistent work and close attention and application to the special study of diseases of women, Dr. Phillips has proven what one can do in this country if he will try and help himself. He is an indefatigable laborer and "by his works ye shall know him." Dr. O. S. Runnells presented a carefully prepared paper on the physiological action of iodoform, iodine, iodized phenol, tannin, calendula, and hydrastin, when applied to the cavity of the uterus. To appreciate this paper, we must refer the reader to the printed transactions. In his paper on "Electricity," Prof. B. F. Betts, of Philadelphia, gave us a feast fit for the gods. Although the author omitted that lately introduced form of elec-

tricity, in diseases of women, called static electricity, his paper teemed with valuable suggestions and important facts that, if followed, we will venture the remark will bring forth fruit that cannot but be appreciated by all who give attention to this branch of medicine. The properties of static electricity render it more attractive and repulsive in its powers than any other form. If the hand be brought near the conductor of the electrical machine while it is in action, a curious straining or wave-like sensation is experienced, similar to the feeling of the impression made on a uni-ocular ovarian cyst when tapped lightly. If the hand be brought closely to the conductor, sparks may be seen passing between the hand and the conductor, which produces a sharp pungent sensation in the skin and in a short time a peculiar eruption on it, which is often surrounded by a little inflammatory blush. As to the degree of application of static electricity to uterine disorders, we are compelled to give our testimony in favor of the galvanic form over all others. After a faithful and honest trial of ten or twelve years, exhausting many hours and dollars in experiments, both on ourselves, friends, and patients, we have selected galvanism as our favorite for office work and results obtained that were not mistaken. Of course, like Prof. Betts, we employ a combination office machine that permits the use, in a moment, of either galvanism or Faradization, without using a switch or changing jars. Prof. Betts' paper will be read with pleasure after the printed proceedings are out. Of late, the French are giving a great deal of attention to the treatment of chronic inflammatory conditions of the body and of the interior portion of the uterus by the *intra-uterine chemical galvano-caustic*. The JOURNAL OF OBSTETRICS will give, in this edition, or later, a carefully translated article on this subject.

Owing to the lateness of the hour, other papers were read by title and referred to publishing committee. Dr. C. B. Kinyon, of Rock Island, Illinois, read an interesting paper on "Intra-uterine Stems and Internal Medication." The doctor gave us a very well prepared article, and although not especially in love with the character of the subject assigned, he would, like a good soldier, "obey orders." Another member felt a disposition to treat his paper with contempt, as he had no sympathy whatever with the treatment of any disease of the uterus with the intrauterine stem, therefore his experience was limited to what he had read and had learned. On the internal medication of the uterus he had had some good results, and in some cases thought a judicious employment of them might be admissible. The work of the bureau was closed by some very interesting remarks made by several present, but whose names we could not learn. This omitting the names of speakers, or not giving them sufficiently loud to be heard in all parts of the room, with their location, is a sad oversight and

hereafter should be correctly noted by all chairmen next year, and corrected. Dr. Comstock, of St. Louis, gave some good advice, and desired to emphasize one caution to the younger and more enthusiastic members, "Treat the uterus kindly; be gentle in your work about that organ." He did not believe in the intrauterine stem. One or two concave hard rubber discs for prolapsus of the uterus and vaginal walls were presented. After being recommended and objected to as is usual with the introduction of any form of a pessary before our institute, the meeting was closed by a few words of congratulations and thanks by the chairman. It is with pleasure we note the change of spirit in our institute that is gradually, but surely, coming; tolerating views that are not always in accordance with the opinion of those intolerant bigots, whose only cry is, "you are rapidly running to empiricism."

PHILIP PORTER, M.D.

—AMERICAN INSTITUTE OF HOMŒOPATHY.—The Bureau of Gynecology had for its subject, "Uterine Disorders; Methods of Treatment and Medication." The following papers were read: "Intra-uterine Medication," L. A. Phillips, M. D.; "The Local Action of Iodoform, Iodide, Iodized Phenol, Tannin, Calendula, and Hydrastis," O. S. Runnells, M. D.; "Topical *versus* Internal Medication," J. C. Wood, M. D.; "Dilatation as a Curative Measure," E. T. Blake, M. D.; "Uterine Deviations," M. T. Runnells, M. D.; "Electricity: Its Application," B. F. Betts, M. D.; "Intra-uterine Stems," S. P. Hedges, M. D.; "Pessaries: Their Application," Philip Porter, M. D.

Dr. R. Ludlam presented a condensation of a paper on "Hot Water as a Topical Application in Uterine Disease." He said in substance that hot water had the peculiar merits of being always safe, available, effective, and does not interfere with or modify in the slightest form the use or action of any internal remedy, something which cannot be said of any other agent. It is so available that it can be safely used even in the doctor's absence, and thereby saves time when from the nature of the case there may be no time to lose. There are no cases in practice where promptness is so important. He gave a history of the employment of hot water in uterine therapeutics, and followed with a detail of the methods of application: 1, by the syringe; 2, by the irrigating douche; 3, by the sitz bath, singly or in combination; 4, by local application to the lower abdomen; 5, by hot sponges surgically.

The modes of operation include: 1, through the local vascular system for the relief of pelvic congestion; 2, through the effect of moist heat upon the inflamed peritoneum; 3, also upon the various

forms of pelvic cellulitis before suppuration ; 4, also upon the abundant nervous supply at the vaginal roof, and especially about the abdominal cervix.

The clinical indications for the use of hot water were stated as follows :

a. In certain kinds of acute puerperal inflammation, such as peritonitis, overitis, vaginites, lymphangitis and phlebitis.

b. In sub-acute and chronic perimetritis, existing with or without effusion.

c. In pelvic hæmatocele.

d. In spasmodic and neuralgic dysmenorrhœa ; in these disorders it acts as a cervical or menstrual anæsthetic ; it can be thrown into the vagina upon the very roof, where the nerves are located. For dysmenorrhœa it is infinitely better than the much used gin.

e. In pelvic abscess it will allay pain where suppuration cannot be prevented, having the same action as a poultice.

f. In post-partum hæmorrhage and in hæmorrhage from uterine carcinoma it acts better than the tampon.

g. In hysteralgia it is a counterpart of nerve stretching.

h. In relapsing ovaritis and ovaralgia, in which it relieves suffering without sowing the seeds of the anodyne habit. The pernicious effects of morphine, opium, atrophine are avoided.

i. In cases of cervical leucorrhœa with laceration, engorgement and glandular inflammation.

There are also contra indications. Like all good things, it has its limits. Its excessive use devitalizes the tissues and may precipitate effusion and suppuration. The secondary effect may be, if used excessively, to increase and make chronic a pelvic congestion.

C. G. Higbee, M. D., read a paper on "Topical *versus* Internal Treatment of Uterine Disorders:"

"The physician who would ignore the progress that has been made in gynæcological surgery during the last few years would be left far behind in the race for superiority, and he who fails to recognize and bring to his aid homœopathic treatment is certainly doing his patients an injustice and depriving himself of one of the greatest resources in medicine. The more accurate pathological knowledge of uterine diseases now attainable enables the scientific physician to add to the objective and constitutional symptoms the pathological symptoms, and thus have a complete picture of the disease in view to aid him in selecting the curative remedy. Armstrong, more than a century ago, says that 'patients should guard against all the passions of the mind that may agitate it, as grief, uneasiness, anger, etc.' We of this generation need not go out of it to get unimpeachable evidence that the mind has great influence over disease, and particularly over diseases of the female sexual organs. At the meeting of the State Homœopathic Institute of

Minnesota last May, a case was reported in detail and diagnosis confirmed by counsel. The patient was said to have metritis, both of fundus and cervix, retroversion, ovaritis, together with convulsions and partial paralysis after cramping, these attacks being frequently repeated. The patient not being able, as was supposed, to even turn herself in bed, she, unaided by any person, sought aid from superhuman power and immediately got up and walked, and continued to do so. Under the usual mode of treatment, local and constitutional, it would have required several months to accomplish this cure. This is direct evidence to prove that many of the forms of uterine disease are of nervous origin, and can be cured by *any* treatment, local, internal or mental.

"All of the diseases under consideration might properly be classed under two heads, those of nervous origin and those of traumatic origin. We know that when the nervous supply is cut off, the part dies. If only the motory nerves, then only motion is denied, etc. So when from any cause, inherent or acquired, the normal nervous vitality of the pelvic organs is lessened, congestion hyperæmia and inflammation will follow. In the same way the normal support of the uterus is relaxed and displacements with all its long train of symptoms follow. How shall we restore our patient to health?

"First of all, place her with surroundings, as far as possible, conducive to rest and peace, a room where there is fresh air and sunshine and a diet comprising good milk, grain and vegetables for food. The proper homœopathic remedy will hasten the cure even though recovery was probable without it in time. Again, soothing local applications, those that cause no revulsion by their use, will be grateful and remedial. Applications through the speculum, however, should be avoided. Use the speculum for diagnosis and where surgical operations are necessary, but seldom at other times. It is a safe rule and one that I have never seen formulated that we may use any means for the relief of our patients in gynecology, which gives immediate relief and which within a reasonable time thereafter show no symptoms of any unfavorable reaction.

"It is probable that all of the diseases of the uterus arising from nervous causes can be cured by internal treatment alone, although some cases improve much faster by using local treatment. I include pessaries in this, at the same time."

The Bureau for 1888 will be composed of the following: Philip Porter, M. D., Chairman; L. A. Phillips, M. D., Boston Mass, Secretary; Drs. E. M. Hale, R. Ludlam, S. P. Hedges, L. L. Danforth, T. G. Comstock, A. Claypool and B. F. Betts. The subject will be "Uterine Therapeutics."

(Several of the papers read will be published in the September issue of this journal.)

—OFFICIAL HONORS—Dr. C. C. Huff, of Huron, Dakota, has, by the courtesy of the Governor, been appointed President of the Territorial Board of Health. While we don't agree with the good doctor on his color of politics, we nevertheless offer our hearty congratulations on his success, and only hope this position is but a stepping-stone to greater influence which may be turned to good account for Homeopathy in the West.

—THE "NEWLAND'S COLLEGE OF MIDWIFERY" has for a motto these words: "Woman's Proper Study in the Field of Medicine is Midwifery." The following announcement indicates how Prof. Henry Newland stands on the question of "women in medicine." The editor does not endorse his sentiments, but the following was sent for publication:

"From the experience of other cities, extending over quite a number of years, medical schools for women have, to a certain extent, proved more or less a failure; this has been owing more or less to the fact of compelling women to go through the whole curriculum of the medical and surgical sciences, which are mostly distasteful and repulsive to her delicate senses, than to a want of mental capacity on her part. Admitting and fully recognizing that women are capable of assuming and maintaining as high a rank in the profession as men, her tender and sympathetic nature, except in a few isolated cases, is hardly able to withstand and endure the many trials and hardships of an active medical practice. The many cares, broken rest, irregular meals, and exposure of all kinds to which physicians are subjected, are very fatiguing and weary to both body and mind; the constant contact with distress and sufferings of all kinds is in every way distasteful and unpleasant, more especially to a woman. There are even many worthy men who have received a profound and thorough education in medicine that have abandoned the profession solely on this account."

—OBITUARY—SCHROEDER.—Again we are called upon to unite in paying a common tribute—common because such men as Prof. Schroeder were above party lines and feelings—to one who has done so much to strengthen our special branch of medicine. Although his field of labor was far away, Americans know how to appreciate his worth and join in sending condolence to his family. Prof. Schroeder was a progressive man for a German, and one who loved Americans for their indomitable will which sent them so far away from home seeking knowledge. In common sympathy we extend our hand to his personal colleagues who knew him but to love him for his unselfish regard for the feelings of those who were his opponents in life. Our personal relations with Professor Schroeder were of an uncommon nature, as he at once placed us under obligation to him the first time we called during our hospital work in Berlin. Well do we remember his warm grasp of the hand when he said in somewhat broken English, "Yes, doctor, we will give you the privilege of witnessing a laparotomy almost every day." It was here we learned his method of treating the pedicle by placing the patient between himself and the light and transfixing it with a needle after he had located the blood-vessels. He certainly was a very successful abdominal operator. It was Prof. Schroeder who was called to London, from Berlin, to attend the Duchess of Connaught in her last confinement when the attending physician anticipated a difficult labor. Prof. Schroeder was original in his special work, and had he been spared (he was comparatively a young man) he must, no doubt, have stood at the head of the profession in Europe. Prof. Virchow, who conducted the post-mortem examination, found the cause of death due to cerebral abscess which had become encysted, and had broken into the right ventricle of the brain causing acute inflammation.

With Madame Schroeder we mourn for the loss of one whose place cannot be filled easily from our ranks, and trust her lonely hours may be occupied with pleasant thoughts of the benefactor who, in life, had contributed so much to the successful treatment of womankind during his short career.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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No. 5.

SEPTEMBER, 1887.

VOL. IX.

PESSARIES AND THEIR APPLICATIONS.*

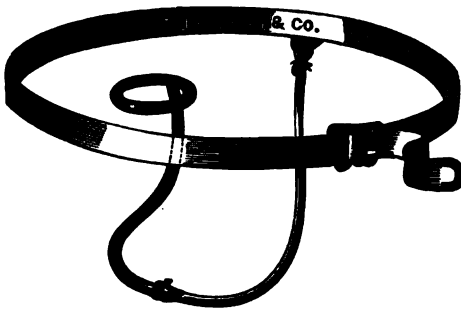
BY PHILIP PORTER, M. D., DETROIT, MICH.

In all applications of the principles of mechanics to the treatment of uterine deviations, there arises a variety of instruments of great diversity of size, shape, material or construction; each claiming attention to some peculiarity of design for correcting and maintaining in place a uterus that has been occupying a false position within the pelvic cavity. Thus it is that there are many features to study and consider in this countless array of uterine supporters. I shall, however, confine myself, in description, to the form known as the vaginal pessary.

With the application of the vaginal pessary, we will always find advocates for and against their use; some advising, others condemning, but the *experienced* gynæcologist knows

* From the Transactions of the American Institute of Homœopathy, 1887, Revised, with the addition of notes and illustrations.

to what extent they have contributed to the comfort of woman-kind, and his words of commendation are to be valued more than the ranting of those whose only experience



No. 1.—Cutter's Ring Pessary.

is based on a hypothesis and a rabid desire to condemn that of which they know not. Neither is it, on the other hand, to be inferred that the employment of the pessary can not become an *abuse*.

I have witnessed cases

where the cup or disk of a Cutter (No. 1), McIntosh, Farro, Wadsworth or Herrick pessary, was found buried within the uterine cavity, and had been incarcerated there for weeks, producing painful uterine spasms. In one case the cervix had contracted closely down about the stem of the cup. I have seen a Zwanck's (No. 2)



No. 1.—Thomas' Cutter's Cup Pessary for Prolapsus.



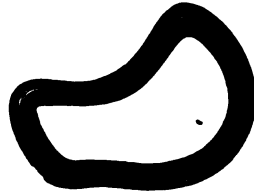
No. 1.—Cutter's Cup Pessary.

pessary, that had been worn continuously for several months, cut an opening through which the urine escaped from the urethra. I have also met with cases where

an innocent Meigs', by pressure, had made a furrow showing the shape of the ring in the posterior cul-de-sac, cut entirely through the vaginal tissue. With a closed lever Hodge (No. 3) I have seen several that, having been



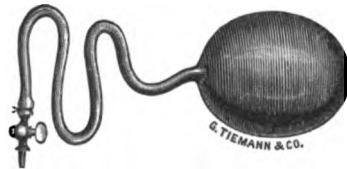
No. 2.—Zwanck's Pessary.



No. 3.—Hodge's Closed Lever.

neglected, were found completely cut through the anterior wall of the vagina into the bladder. The intra-uterine stem has, no doubt, more charged to its accident account than any other form of pessary. In consultation I have seen two cases where the patient was suffering from the presence of an ordinary soft-rubber air-bag (No. 4) which had been selected without regard to the size of the woman's pelvic cavity, the bag, when inflated, distending the vagina until the entire space was not only filled with the bag, but every thing was crowded out of the normal position, producing great distress. The block-tin pessaries and those made from other materials have been known to produce recto-vaginal and vesico-vaginal fistulæ, or some inflammatory condition, as peri-uterine cellulitis or true pelvic cellulitis.

Before taking up the study of any form of pessary we must first give the instrument its position in medicine, and that is in the mechanical department, assigning it with the list of palliatives or temporary treatment. Be it understood, in considering all treatments of diseases of women, that there should



No. 4.—Soft Rubber Inflatable Ball Pessary.

be remembered one important fact, that may prevent those opposed to the employment of pessaries from appearing ridiculous, and that is, that there are now three distinct applications to the treatment of diseases of women—one purely mechanical or palliative; the others, electro-therapeutical and therapeutical. The first an expedient, the others curative.

Originally the word pessary meant a soluble substance placed within the vagina; now called a suppository. Several coined names have been substituted for the old term by later writers, one being "hysterophores," suggested by Barnes, taken from the Greek *hystera* womb, and *phereo* I bear.

The objections that have been urged against the employment of pessaries have been from a source that did not give much character to their argument; usually those who have seldom tried them, or so rarely that their experience was not equal to a successful employment of the instrument. Suffice it to say that the advantage gained in their application far outweighs all theory or the unfortunate results from their use by the novice. If we acknowledge that their employment is only palliative and temporary, this should be sufficient for their retention as a permanent adjunct to the successful treatment of diseases of women. Like the application of a splint to a fractured limb, a truss to a hernia, a brace to a spinal curvature or a case of talipes, so must we accept the mechanical assistance of a properly adjusted pessary.

The principal object to be obtained in the employment of a pessary in a given case must be thoroughly appreciated by the physician before he makes any attempt to select his instrument. This important feature of the case decided upon, then comes the measurement of the pelvis; if we wish to support the uterus only, lifting it up to its normal plane, the shape and character of the pessary must be selected correspondingly. If to retain a uterus that has been occupying

a malposition for years, this fact must be given due weight in making our choice of an instrument. If to correct any displacement of the vagina, as an anterior or posterior prolapse, this significant fact again requires a special pessary, and so on, each case demanding that the instrument should be adapted to meet all the indications that may be present. We have known of physicians ordering ready-made instruments for their cases. No wonder that the pessary falls into disrepute.

One more thought regarding the selection of a uterine support. As long as the vagina retains any amount of contractility it should be our first duty to preserve rather than destroy this property and make use of the same in our treatment. Finally by way of an introductory, we must add that the practitioner who is not a mechanic should not trust himself to the employment of a pessary in his practice. Those who do so without becoming familiar with mechanical principles will find themselves making many mistakes.

The following cautions should be observed :

1. Never introduce a pessary when there is a metritic inflammation, acute or chronic.
2. Be sure you have selected the appropriate instrument.
3. Do not select a pessary that is too large or too small.
4. Always examine your cases every few days until you are satisfied that the proper instrument has been selected.
5. If possible teach your patient to remove and introduce the pessary herself, especially if she resides out of the city.
6. A pessary should only be worn during the day. Of course there are exceptions to this rule in cases of retroversion or flexion.
7. Remember this "Golden Rule," in the mechanical treatment of uterine displacements ; always adjust the pessary to the patient, not the patient to the pessary.
8. A profuse leucorrhœal discharge from a patient who has always been free from it before the introduction of a

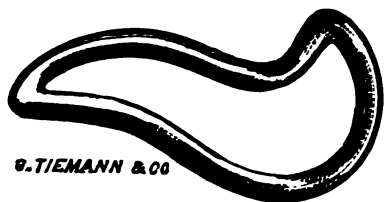
pessary is an indication that it is too large or that it presses some part too firmly ; faults to be corrected at once ; leucorrhœa always destroys the elasticity of the vaginal tissue, and, while almost always present in a slight degree during the wearing of a pessary, any increase should be regarded with suspicion and a careful examination of the instrument made.

As the uterus is sustained in its lateral aspect by musculo-cellular processes, which spring from the sides of that organ and between the folds of the peritoneum, join the sacro-iliac symphysis and its neighboring region, we should ever bear in mind that in any deviation, either backwards, downwards, or upwards, the anatomical relations and, with these, the physiological conditions become disturbed and there is a greater or less degree of pain and discomfort ; a derangement of the general health.

Without considering the etiology, the pathology or the therapeutics of uterine displacements, these factors must be incidentally referred to, so far as to serve our purpose. This reference limits itself in the main, to those deviations which we are of necessity compelled to notice in order to introduce corrections or treatment by mechanical means. Briefly we will state that the uterus swings in a hammock formed by the various ligaments, of which it is not our province to touch upon. But, some say, do not the bladder and uterus move up and down with each respiration ? We reply yes, therefore, when adjusting support from below, this peculiar physiological movement of the uterus should be appreciated and a pessary employed that will not cause a fixation of that organ.

For the adjustment, there are several indications, it would seem, that are plain ; the principal one being to keep the womb in a natural position. Having replaced the uterus first, by any of the various means at our hands, the next thing is to decide upon some properly fitting mechanical appliance. Personally, I always remember the so-called

Hogarth's curves of the posterior walls of the vagina and the lateral approximation of the sides by the pubo-coccygeus muscle. I invariably select out of one of my drawers of pessaries an Albert Smith (No. 5) or a closed lever



G. TIEMANN & CO

No. 5.—Albert Smith's Pessary. (Long Curve.)

Hodge as the one best suited to fulfill the requirements and the one most easily worn. But in choosing this pessary it is necessary to bear in mind, certain qualifications — with the aforesaid rules in our minds,

we must also take the following precepts into consideration :

1st.—The pessary must be just long enough, no longer, to carry the cervix backward beyond the centre of gravity ; that is when the patient is in the erect position or in Sims' position ; if, however, in the latter, never lose sight of the pelvic curve. By carrying the cervix backward, the fundus, obeying the law of gravitation, tilts forward and thus the strain is taken off the ligaments and surrounding connective tissues. *En passant* permit me to add that I observe this rule, which has been of great service to me, many times, and that is, I adjust all pessaries for the retention of a ret-

No. 5.—Albert Smith's Pessary, Front View.
(Sharp Curve.)

G. TIEMANN & CO

No. 5.—Albert Smith's Pessary, Side View.

roverted uterus, with the patient in the erect position, that is for the verification of the correct selection of the pessary ; while in a case of anteversion I adopt supine position.

2nd.—The posterior or long curves—termed by some

the uterine curves—must be of such a length as will carry the posterior *cul-de-sac* well upwards. The instrument must be selected with regard to the depth of Douglass' sac; also whether the pouch is filled with scar tissue or not. This fact, having been overlooked by one of my colleagues in another city, when adjusting a pessary to a simple case of retroversion, the instrument produced so much distress that the lady almost had a convulsion. The *cause* was ascertained by this significant symptom; when in the erect position she experienced all of the uncomfortable symptoms, which were relieved by again assuming the recumbent position. All symptoms disappeared on removal of the pessary which was of vulcanized rubber.

On further examination I found a mass of cicatricial tissue in the posterior *cul-de-sac* which could be traced to her last confinement but had never been discovered before. Two months later I removed the scar tissue and the result was a surprise to all interested. One month after the operation this same pessary was introduced and worn with comfort by the patient. When adjusting a pessary to carry back the cervix always remember the normal position of the fundus uteri is about three inches above the upper border of the symphysis. If the *cul-de-sac* of the vagina is carried well upward, the strain is taken off the utero-sacral ligaments.

3d. The same curves in the anterior aspect or perineal portion of the instrument must be such as to accurately fit the perineal body. In other words the patient should be able to sit down on a chair or ride on horseback, and more, the perineal or anterior short tip curve should be such as to rest evenly and gently against the upper or anterior wall of the vagina behind, but close up to the pubes; the fulcrum or support being made by the antagonism between the pressure of the anterior and posterior curves. If the mechanical relation between the two points be unequal or not in harmony, discomfort to the patient will follow. If the long

curve be too short, expulsion of the pessary will be endangered.

4th. Always employ as narrow an instrument as possible to avoid stretching or pressure on the sphincter vaginæ; the retention of the pessary depending not upon the outlet of the vagina as many suppose, but upon the nice adjustment of the curves of the pessary to the vaginal curves, and no antagonism of these two points. With an ordinary case these points of observation are all that are necessary; but in a case of retroversion with a large, baggy, relaxed vagina, having atonic walls, with the utero-sacral ligaments elongated and the uterus almost, if not quite, in the second stage of prolapse, these rules governing the selection of an instrument will not hold good. In these cases the ordinary pessary selected by the above rules will oftentimes fail because of

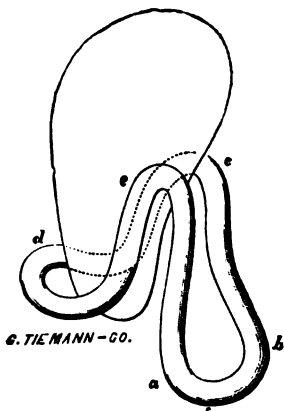


No. 6.—Kinloch's Anteversion Pessary.

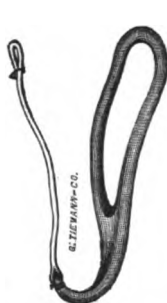
the posterior *cul-de-sac*; its bar carrying upward and backward the *cul-de-sac*, but leaving the cervix in its former abnormal position, pointing outward toward the axis of the vagina. With these cases the great variety of pessaries called "Natural

Uterine Supports," such as the McIntosh, etc., find their ripest field of usefulness. This class of cases with all the associated symptoms of distress and discomfort can be relieved almost instantly by any instrument that is constructed on the plan of the cup and stem pessary, but preferably by the Studley. The latter having all the salient points of mechanism that the Cutter ring pessary and the Herrick have, and yet being confined entirely to the vagina, while the others have the abdominal bands to lend support. The Studley pessary we regard as the instrument to which we may look for a number of excellent improvements. The Studley presents *sine qua non* of vaginal pessary mechanism, and will do more to correct retro-displaced uteri, especially if the vaginal walls and retro-pelvic ligaments be relaxed, than

any other form of appliance. The Studley instrument is a Smith pessary with a ring attached to the posterior arch in which the cervix is to rest, and which by lever action ele-



No. 7.—Thomas' Retroversion Pessary.



No. 8.—Cutter's Pessary.



No. 9.—Thomas' Modification of Cutter's Pessary.

vates the organ and forces the cervix backward and the fundus forward, and is, for my use, preferable to the vagino-abdominal pessary. It bears a slight resemblance to the



No. 10.—Thomas' Cutter's Pessary with Cervical Rest.



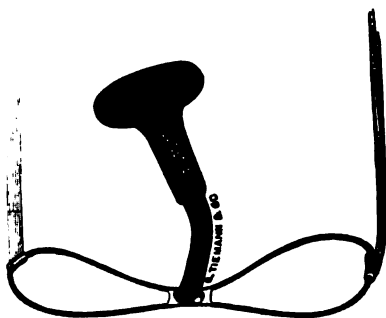
No. 11.—Thomas' Modification of Cutter's Pessary.

Kinloch Anteversion pessary (No. 6) except the single curve of Kinloch's is replaced by the double curve of the Albert Smith, the posterior one being sharp. The action of the

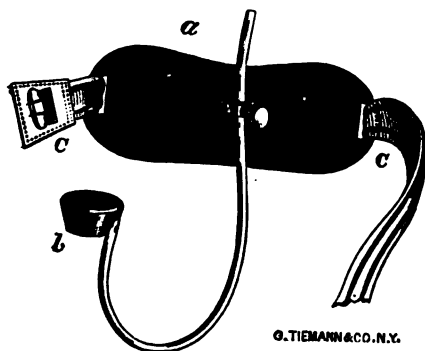
ring is to retain a persistent hold upon the cervix in its posterior aspect, and the balance of the pessary, which may be modified to correspond with the ordinary Hodge (closed lever), fulfills all of the other indications spoken of in the general use of the pessary.

The advantages of this Albert Smith pessary with the cervical ring attached (Studley) are so superior to those of the numerous vagino-abdominal supporters that it seems superfluous to refer to them. First,

with this instrument when the ring grasps the cervix it also raises the uterus to its normal plane within the pelvis, but unlike the other supporters it also prevents the fundus from falling forward beyond its normal angle, while the



No. 12.—Hornby's Pessary.

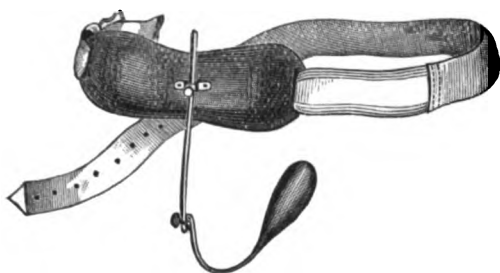


No. 13.—Tieman & Co.'s Uterine Pessary and Supporter.

other instruments, with no vaginal support whatever, depend entirely upon pushing upward the entire organ. But from the shortened condition, or from long disuse of all the supporting ligaments, the body of the uterus assumes the anteverted position, which must be corrected or a new trouble presents itself.

There is a condition, however, fortunately rarely met with, that neither the vagino-abdominal ring nor the Studley will correct, and that is shortened utero-pubic ligaments from disease or long continued displacement. This con-

dition I correct by what I term the expanding process. This is accomplished by the probe-stretcher or the pessary. The first is an ordinary uterine sound, which I had made,



No. 14.—Rozer's Pessary.

after Dr. Studley's idea, with a projection about half an inch long attached to the body of the instrument nearly one and one-half or one and two-thirds of an inch from the

point. Something like a two-tined fork, only one point is longer than the other and the short prong is set at a right angle from the sound for a distance of a half inch before it assumes a parallel position. This shape of the sound enables the operator to catch the posterior lip of the cervix for manipulation and also the projection prevents the sound from passing too far within the uterine cavity and injuring the fundus. The second instrument is a tongue attached to a rubber bar, which has been fastened to an ordinary Smith pessary. This latter treatment should not be prolonged over twelve or twenty-four hours. In cases where the cervical projection is almost lost; when the junction of the vagina is so low that it is impossible to grasp it for the purpose of manipulation, this treatment can not be carried out.

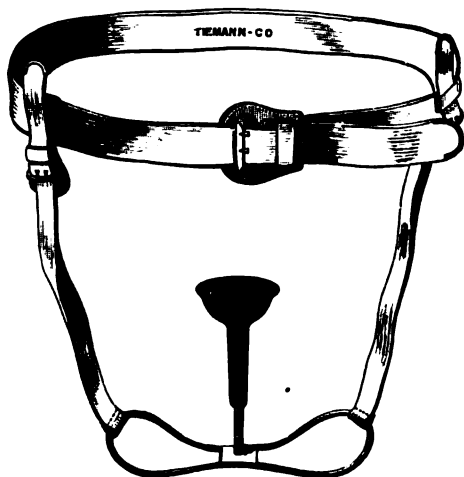
The supporters made with large curved bars, like the Thomas retroversion pessary (No. 7), do not, as claimed, correct the displacement by the bars passing up behind with firm pressure on the uterus (examine a woman in the erect position after



No. 15.—Babcock's Pessary.

one has been introduced and the malposition corrected) but simply on the principle and basis of the law of gravitation. To assist this instrument it is an excellent plan to have your patient assume the knee-chest position, not only at the introduction of the pessary but several times during the day and especially on retiring at night.

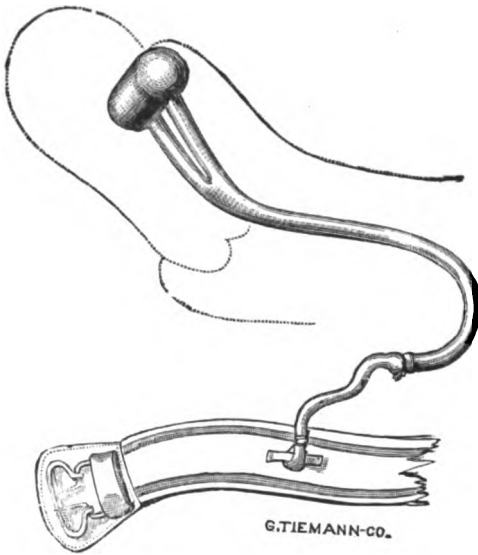
There is also another condition which oftentimes prevents the pessary from carrying out its mechanical principles and that is destruction of the perineal body. This, again, is a condition of degree, the result of the treatment depending upon the extent of the injury. If the perineum be entirely lacerated and the strength of the sphincter gone, with an added heavy sub-involuted vagina and a disposition to posterior prolapse (rectocele) we can anticipate but little aid from any vaginal pessary. We must either furnish a new perineal body or resort to some other



No 16.—O'Leary's Pessary.

mechanical support outside the body. The former treatment, the profession are almost united upon, the method of the surgical operation being the only question. I look upon the operation for the repair of a lacerated perineum as one of the most scientific bits of surgical work that we are called upon to perform; ignorantly carried out it is apparently one of the simplest operations; correctly performed, one of the most complex and trying procedures in gynecology. The results, too, are as various as the

methods for relief—one affording permanent and perfect satisfaction—the other dissatisfaction and discomfort with disappointment, usually, the patient having been promised



No. 17.—Thomas' Cutter's Pessary with Large Transverse Bar.

a cure. It is astonishing how little attention is given this operation by the profession; an operation involving so much and yet so seldom properly performed.

If there are reasons why the operation for the repair of the perineum should not be performed, we must then look to vagino-abdominal appliances, such as Cutter's pessary (No.

8),* Thomas' modification of Cutter's (No. 9), Thomas' Cutter's pessary with cervical rest (No. 10), Thomas' modification of Cutter's (No. 11), Hornby's pessary (No. 12), Tieman & Co.'s uterine supporter (No. 13), Rozer's pessary (No. 14), Babcock's pessary (No. 15), O'Leary's pessary (No. 16), or Thomas' Cutter's pessary with large transverse bar (No. 17). Besides these vagino-abdominal pessaries, a Zwanck or some of the disks may be useful.

The question of externo-internal support is one embracing many interesting mechanical points as well as those of comfort. If the woman be advanced in years, she will tolerate with better grace an abdominal harness; if young in

* See also Fig. 1.

years, it will be endured but for a short time. The uterus being in the younger woman more susceptible to the punching and irritation of the cup, and the vaginal fornices to any manipulation except those of a most delicate nature, while that organ in the elder submits to almost any treatment without complaint on the part of the patient.

According to indication, a different form of supporter is required. Supporters held in position by attachments or bands about the body are employed in cases of retro-displacement, in which a lever pessary fails to retain or hold the organ up to its proper level; also, we might add, in condition of adherent uterus. Of all the instruments of this character, we have given, the Cutter or Thomas modification may be regarded as the standard supporter. One serious objection to these forms of pessaries, aside from the danger to the patient, is the expense; they are too much of a luxury for the masses. Finally we are compelled to acknowledge that the ideal supporter for prolapsus has not yet been constructed.

Some of the dangers of this class of pessaries have already been pointed out; but there are one or two more I would like to mention, especially that of cellulitis. This pessary, above all others is an enemy to the cellular tissue and the lymphatic system of the pelvis. I suppose by pressure and, many times, through a want of cleanliness. Notwithstanding the elasticity of the attachments of the vaginal portion of the support there is sufficient persistent pressure to produce excoriations and offensive discharge with early ensuing ulceration if the cause is not removed. The longer any pessary is left without being cleansed the more dangerous it becomes.

(To be Continued.)

ON THE RELATION OF THE SYMPATHETIC
NERVOUS SYSTEM TO REFLEX INSANITY;
AND ESPECIALLY TO INSANITY SECONDARY
TO LESIONS OF THE FEMALE GENITALIA.

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The question of the secondary involvement of the mental faculties in disease of distant areas of the body has occupied my attention for the past two years. A brief exposition of the pathology of reflex insanity has already appeared in *The American Homœopathic Journal of Obstetrics and Gynæcology*,* but, to me, the theory there advanced has never until lately been worked out in more than a desultory and unsatisfactory manner. It is indeed difficult to take up any subject of nervous disease without entering into full explanations, and it is especially in reflected nerve phenomena that our task becomes doubly hard, if we set ourselves to unraveling the chain of connections by which all the forces and functions of the body are bound together, and without which the vital force ceases its union with organic life; for the essence of vital force is not alone organization by development from its own energy, but lies also in the maintainance of nutritive, formative, and functional activities.

A discussion of the initial relations of the vital force to nervous diseases, to the soul, and to that immaterial personality called the mind, though interesting, must be omitted from our arguments; and leaving then these questions of theology and psychology, for a future dissertation perhaps, we narrow our sphere down to what might be simply called the organic sympathy of parts and the constituents of that function.

Maudsley most happily expresses this relative dependency of parts in a quotation from George Herbert:

*Diseases of Women as Causes of Insanity.—Feb., 1885.

"Man is all symmetric,
Full of proportion one limb to another,
And to all the world besides.
Each part calls the furthest brother,
For head with foot hath private amity,
And both with moon and tides."

It is evident that the preservation of a balance of power in organic bodies must depend upon organic communication. In the undifferentiated structure of the *protamoeba* and of the *amoeba* no special means is required to produce harmonious working. Simple diffusion of force through continuity of structure answers all purposes of communication. In higher animals the increasing differentiation requires that isolated tissues should be united into a harmoniously working whole by a co-ordinating mechanism. Such a mechanism we have in the ganglia of the sympathetic system, with its efferent and afferent branches, to which may be ascribed the preservation of tissues and of their normal relationships; while in its excitations and depressions may be traced the causes of exaggerated or of repressed nutrition—conditions of departure from a mutual dependency of the integral factors of the organism—the recognized commencement of disease.

In discussing this function it will be necessary to refer briefly to anatomical relations. The most important in this connection is that the sympathetic system supplies, with one or two exceptions, all sensori-motor nerves, either directly from the ganglia by the side of the spinal canal, or from ganglia near which a nerve passes in its course. These are the afferent fibres of the sympathetic, conveying impressions from the tissues to the ganglia, being centripetal in function. These nerve fibres have important communications with other sets of nerves through the caudate cells of the ganglion that they enter, thus placing them in functional relation with distant areas of tissue. "When these afferent sympathetic fibres pass out of the ganglion they do so by one of the two fasciculi or roots connecting it with the

spinal cord, in which they are prolonged to the primary vaso-motor centre." (Woakes.)

The second set of nerve fibres from the sympathetic ganglia proceed from the central vaso-motor cells to their destination on the coats of the arteries, and are afferent in function, conveying impressions to the vascular factors, thus regulating the blood supply of the tissues. Enough has been said to indicate that the blood supply of one part may be subjected to influences proceeding from any other part, however distant or different in function the latter may be; the influences reaching the arteries in a reflex manner by means of the central nervous system, the afferent impulses being, for the most part, carried by the sensori-motor nerves, while the efferent impulses pass along special vaso-motor nerves.

Hence we have in functional relation the centripetal and centrifugal nerve tracts and the ganglia, which are probably subservient to a dominant sympathetic centre, not yet positively located in man, but placed by hypothesis in the medulla oblongata. By means of these, the elements of the organism are in a position of correlation through a reflex dependency of tissue impressions, which influence nutrition by vaso-motor action and are in turn reacted upon by this same modification of blood supply. Through this it becomes apparent that we have an elucidation of those vague morbid processes, formerly attributed to "a sympathy or consent of parts." For example, through correlation of tissue tracts extensive burns have been followed by duodenal ulceration.

It follows, then, that the function of the sympathetic is that of an organic mechanism, which in normal condition is capable of maintaining the tissues in proper relation to the whole system, to each other and to external nature; but through disturbances of its correlating function becomes effective in producing modifications in separate and distant parts of the organism.

Let us now attempt to harmonize the pathology of reflex insanity with such anatomical and physiological data as we have given.

As a healthy mind is the result of the normal working of a healthy brain, so a diseased mind becomes a manifestation of a diseased brain. The mind, then, instead of being a wondrous entity, an independent source of power, becomes the most dependent of all natural forces; as to its existence a proper relationship of all other forces must be established. To deal with the mind apart from the brain cells would be as absurd as to attempt to handle heat and light apart from the changes in matter by which alone we know them. As there are different kinds of matter, so there are different manifestations of force, and as we rise from common physical matter, in which physical force holds sway, to chemical matter and chemical force, and again higher to organic matter (living) and living modes of force, so we find increasing difficulty in formulating our ideas of the laws that govern the relations of matter and force.

But when we come to brain force, general ideas must not content us; it behooves us to trace the dependency of the mind further than the mere histological elements, even to a ground-work in the nutritive life of the brain cells, or we might call it, the vegetative life. In this way, then, normal brain force becomes directly dependent upon a proper nutritive assimilation of suitable material from the blood by the nerve cell and to modifications of this nutrition, due to vasomotor disturbance, may be traced the initiatory process of reflex insanity.

The more highly differentiated a tissue or cell, the greater will be the disturbance of function, from a given cause, compared to a stoppage of the processes of more coarsely organized tissues or cells. So that in the brain a scarcely appreciable increase or diminution of blood-supply, with consequent modification of nutrition, will lead to a greater degree of functional derangement than the same apparently

insignificant change of blood-supply would produce in muscular tissue.

With the two facts before us, that of the correlation of tissue tracts through the function of the sympathetic in controlling the vascular factors, and that of the origin of mental derangement in vaso-motor disturbance, by which the amount of intra-cerebral blood is altered, either by increase or diminution, we will have little difficulty in harmonizing the pathology of insanity with the data of those cases that arise by reflex irritation. Especially will this apply to those cases secondary to lesions of the female pelvic organs; the well-known rich supply of nerves from the ganglionic nervous system at once impresses upon us the mode of origin of insanity and allied neuroses in over-excitement of the vaso-motors.

It is unnecessary in this connection to refer to the external genital organs except the clitoris, which, consisting as it does of cavernous tissue, receives an unusually numerous supply of nerve fibrillæ. "Small as this organ is compared with the penis, it has in proportion four or five times the nervous supply of the latter" (Savage). Numbers of nerve fibres, belonging to the sympathetic system, accompany the arteries and enter with them the erectile tissue. Between these sympathetic nerves and the spinal nerves supplying the clitoris there exists free communication.

In the vagina much the same arrangement exists, the afferent nerves of the sympathetic returning to the ganglionic centres through the sensori-motor nerves.

The nerve supply of the uterus and ovaries is even of more interest; here, in the uterus, the main nerve supply is derived from the pelvic or inferior hypogastric plexuses, which surround the rectum and send filaments to the uterus and vagina. These are prolongations of the uterine plexus that lies over the bifurcation of the aorta. The uterine branches spring from the sides of the pelvic plexuses, run inward between the folds of the broad ligaments until they

reach the cervix when they turn upward, accompanying the branches of the uterine artery and entering the substance of the organ with them. A large nervous mass situated between the cervix and rectum, arises from the union of branches of the upper sacral nerves and ganglia and a number of sympathetic twigs from the hypogastric plexus: it supplies the cervix chiefly, and is enormously enlarged during pregnancy. The ultimate termination of the uterine nerves is either in the nuclei of the fibre-cells or in the sub-mucous ganglia. In the ovaries, the nerve-fibres can be traced from the hilum into the stroma in the vicinity of the larger vessels, but their ultimate endings in man have not yet been described. Elischer, of Buda-Pesth, states, as the results of his observations on the lower animals, that medullated fibres, after entering the hilum, branch in a dichotomous manner, and lose their medullary sheath when they reach the neighborhood of the vesicles, around which they form loops. The same observer claims that he has traced the terminal fibrils to the cells in the granular layer where they probably end in the nuclei.*

Aside from such exactness of anatomical description, the most important fact, in connection with reflex vaso-motor disturbances, is, that all or nearly all the sensori-motor nerves of the genital tract contain those nerves from the sympathetic system that do not hold direct relation to the muscular fibrillæ of the coats of the blood vessels, but, being efferent in function, reflexly influence the vascular supply of any part by their communications with other sets of nerve fibres through the caudate cells of the ganglion which they enter.

Thus it is that, in tracing the impressions passing from the genital tract to the cerebrum, it will be found that the peripheral stimuli primarily affect the end organs of the afferent nerves of the sympathetic, hence these impressions are conveyed to the ganglion in which the centripetal nerves

* American System of Gynæcology, pages 146 and 175.

communicate with other vaso-motor nerves (centrifugal in function) and finally our primary impression becomes reflexly manifest in modifications of nutrition within such areas of cerebral vascular supply as are governed by a ganglionic centre of weakened resistance.

Should such states of morbid vaso-motor action, remain passive, instead of subsiding, the activity of the cerebral cells degenerates, co-ordination of ideas becomes irregular, with confusion of thought, emotional disturbance, and irritability; while if the vascular derangement become active, we have systematized disorders, with delusions dependent upon a definite derangement of thought.

Numerous illustrations of this reflex vaso-motor disturbance occur in daily practice; note the melancholia dependent upon a disordered liver or stomach, with the lessened resistance to an overflow of visceral impressions; the mania consequent upon the pregnant state with a delirium that is witness to the inco-ordination of brain cells; and the various morbid mental states following lesions of the female genitalia—flexions, versions, neoplasms, narrowing or occlusion of the genital canal and the presence of cicatricial tissue—with excessive irritability (diminished resistance) of nerve centres and the accompanying localized disturbances of neuro-mechanisms.

But if the reflex mental phenomena depend upon morbid sympathetic action, in what manner may we explain personal idiosyncrasies, in this direction?

Following out the theory of the initiation of disease through modification of cell nutrition, we must put the determination of idiosyncrasy in this particular case upon a basis of the manifestation of disease in the part of least resistance, and further than this must consider the tendency of such a part to be dependent for its existence upon hereditary or acquired states of the system. Susceptibility to any entity of reflex mental derangement must, then, depend upon a lessened resistance to reflex impressions on the part

of those ganglionic centres that control the vascular mechanism of the brain.

It is impossible to place exactly the centres that control the vaso-motor branches supplying the cerebrum. Eulenburg and Guttman teach that it is probable they are to be found in the cervical sympathetic, and Nothnagel also was convinced that, "The cervical sympathetic, and especially the ganglion supremum" have a share in the innervations of the blood-vessels of the brain. The investigations of Fisher on the influence of the cervical sympathetic were carried on in cats, the brain pressure being taken with the kymographion, through an opening in the dura mater.* "Faradic irritation of the isolated sympathetic increased the brain pressure in five cases out of eight; in three cases there was a trifling decrease; the constant current produced either no results or a very trifling increase when the circuit was closed. The simultaneous Faradization of both sympathetic nerves was followed, in four experiments by a preliminary quick increase of brain pressure, succeeded by a decrease when the irritation was continued; in all four cases convulsions occurred in the form of clonic extensor spasms and opisthotonos, which were never observed in unilateral irritation and which were probably caused by the decrease or cutting off of the arterial blood-supply to the brain."

Such experiments are not conclusive, but nevertheless I feel sure that in all cases of reflex neuroses we have to deal with a deterioration of that part of the sympathetic system that presides over the nutritive life of the brain, and that this *loss of resistance* on the part of the sympathetic, depends in many cases upon a hereditary depreciation, with, it may be, a superadded acquired neurotic tendency, or it may be dependent upon the latter alone.

This is not to intimate, however, that the direct progenitors of neuropathic children may have been neurotic in tendency. Nor do I preclude this influence. Our knowl-

* Eulenburg and Guttmann.

edge of diathesis is too vague to predicate anything certain. The shading off of inherited syphilis, of climate and of food influences, etc., into a neuropathic diathesis is in many cases difficult to trace, but still there seems to be a certain display of the modifying effect of these various diatheses, in that they all institute constitutional conditions that are associated with a lessening of the resistance of the sympathetic ganglia; what Hutchinson characterizes as a lack of *nerve tone*. Thus, he says, "Perhaps it is further true that in most conditions in which derangement of tone is in question, the disturbance or enfeeblement has reference chiefly to that part of the nervous system which controls the circulation. Whenever the circulation is specially liable to reflex derangements, and congestions or their opposite, occur with unusual facility, we are safe in declaring that the tone is low. It is a part of the business of the nervous system to regulate the supply of blood to various parts, to prevent local arterial spasm, and under varying conditions of daily life to maintain the normal balance of circulation. When this power is deficient the various causes of disease act with greatly increased effect. In many cases, loss of tone may be long continued and so great that we can not but suspect that it depends upon degenerative and permanent changes in the nerve cells."

Thus it is especially in a neuropathic diathesis that the relative stability of the sympathetic nerve centres is lessened in power to resist irritation; becoming a condition in which reflex impressions flow beyond their natural channels, and find outlet in disturbance of the vascular factors of the brain, with consequent enfeeblement of the intellect, the perception, the emotions and the will.

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REMOVAL OF THE OVARIES FOR THE RELIEF OF SOME FORMS OF INSANITY.

BY SAMUEL WORCESTER, M. D., SALEM, MASS.

(Read before the Mass. Surg. and Gyn. Soc.)

In calling your attention to a comparatively new method of treatment for the relief or cure of a certain limited class of the insane, we are at once met with the question what claims has this method to our consideration: to what extent and under what circumstances is the proposed pro-

cedure desirable or feasible, and in what manner can the ovaries be removed with the least danger to the health or life of the patient? These questions have especial force when the treatment proposed is so radical and far-reaching in its results, as the one now under consideration.

I do not propose to discuss in this short paper the best methods of operating; those will vary greatly according to circumstances; this part of the subject belongs to the domain of the surgeon and gynæcologist, into which I am not competent to enter, but I shall consider the subject in a general way from the ethical and alienistic stand-point.

But a few years have elapsed since the removal of the ovaries as a possible cure for insanity was first suggested, and the number of instances reported where this procedure has been resorted to is as yet too limited to enable us to estimate it at its true value, and judging from the past it seems probable that in the immediate future investigation in this direction will receive greater attention in private than in asylum practice. It is too true that our hospitals for the insane are to a very great extent such only in name.

The intimate connection existing between the different viscera and the nervous system has long been known, and the fact recognized that functional or organic disease of the one was generally followed by abnormal working of the other. Further than this it has been noticed that each viscus when diseased has seemed to impress the nervous system in a manner peculiar to itself; and conversely that certain mental states acting continuously or in a forcible manner through the nervous system would involve by selection or affinity certain of the viscera. The connection often existing between the abnormal mental states known as hysteria, melancholia and hypochondriasis and diseases of the uterus and its appendages, and the liver is known to you all.

The disorders of menstrual life for which the ovaries have been successfully removed are fibroid tumors of the womb,

chronic pelvic-peritonitis, persistent ovaritis and ovaralgia, ovarian epilepsy, dysmenorrhœa, menorrhagia, and in short all those lesions which are brought about or intensified by the periodic congestions of menstruation. In many instances when these or other diseases of the generative organs have co-existed with mental disturbance, the latter has been cured or palliated when the former have been removed by remedies or the knife. That this result does not always follow is no argument against the mutual relation of the two diseased conditions, for we know that in other forms of disease the removal of the original exciting form is not always followed by a cessation of the secondary phenomena dependent upon some subordinate or remote nerve centre. For example, long-continued irritation of a peripheral nerve from some exostosis or a spicula of bone may produce typical epileptic convulsions, which do not by any means cease upon the removal of the offending cause.

Every physician of large experience has observed cases of mental disease in which the periods of exacerbation have been co-incident with the menstrual period—whilst in the interval the patient may be wholly sane or comparatively so, and to such cases the term ovarian insanity may be applied, and for the relief of such cases has extirpation of the ovaries been suggested.

Aside from the dangers incident to the operation and which have been decidedly lessened by the advance of modern surgery, the main objection to this method of treatment will be on the score of depriving the woman of the means of producing offspring, of unsexing her, and to a certain extent of changing her nature. Such an objection would be of prohibitory value perhaps, were we considering the case of a sane woman, though some philanthropists and reformers would except the case of habitual criminals or vagabonds, as for instance that of Margaret Jukes the notorious mother of criminals; but we are dealing with the case of a woman who is already deprived of all that makes her a

member even of the human family and raises her above the level of the brute, *viz*: reason. An insane woman is not in the ordinary sense a member of society or the body politic, and at all times her death is considered far more to be desired than a life of such a character; instances, too, are not rare where the insane woman has during the continuance of her insanity conceived and given birth to children to whom were transmitted the same dreadful inheritance; again in what possible way, or from what stand-point of ethics, morals or religion, is it desirable that a person who has once been insane, except for a very short time, should be permitted to transmit this taint to her children or children's children. The removal of the ovaries in some cases would at once bar the possible production of diseased children and restore the woman to health and society. In other words, there would be all to gain and nothing to lose.

As a curative measure, however, this procedure seems especially fitted to those cases where there seems a clear connection between the insanity and ovarian irritation: the indications for its use would of course be more clear in those cases where the paroxysms occurred at or about the time of the menstrual flow.

In my opinion the absence of appreciable lesion of the ovaries would not contra-indicate their removal in a case of this kind though its presence would make such removal more clearly demanded. In cases of long standing I should anticipate that time would bring about a cessation of the secondary morbid nervous phenomena even after a year or two had elapsed after the operation. In recent cases I should anticipate prompt and favorable results.

The following cases have been reported by Dr. Wm. Goodell, of Phila. and should serve to encourage us to investigate the subject carefully.

Case I. A married lady, thirty-eight years old, whose brain gave way from over-anxiety and from nursing a sick child night and day for a long time. The first token of

insanity was night terrors, which began to distress her for two or three days before the menstrual period. These steadily grew worse until Sept., 1878, when she presented the following symptoms: "Several days before the menstrual flux, hallucinations on every subject take violent possession of her, and she becomes so violent as to need locking up. These attacks last during the continuance of the flow and for a week afterward. The remaining part of the intermenstrual period, which lasts from a week to ten days, "she eats and sleeps enormously, like a ploughman," and exhibits mere traces of her hallucinations. She has without benefit been an inmate of several insane asylums. Two distinguished alienists have, however, held out the hope that with the change of life, reason would return. Examination showed a congested and hypertrophied womb, measuring three and a half inches. The left ovarian region was exquisitely tender, but the ovaries could not be outlined. There were all the lesions discoverable, but in view of the history of the case and the opinion of the two experts, an operation was decided upon. This was done by a vaginal incision on Nov. 28, 1878. She recovered from the operation excellently well, although she could not be kept in bed beyond the eighth day except by the use of undue violence.

Although her catamenia were effectually stopped, the menstrual molimina still kept on. They returned with great regularity every month, and were attended with exacerbations of mental disturbance, but in a less degree. Early in the spring of 1880, after a duration of a little over a year, these efforts at menstruation ceased, and she has since remained well, and able to assume the care of a family of eleven persons.

Case II. An unmarried lady of thirty, had for many years a chronic ovaritrix, which had terribly crippled her in mind and body. During the acts of defecation and of menstruation her sufferings were excruciating. At all times she was never free from gusts of ovarian pain often unbearable. In

addition, she flooded alarmingly at every monthly period when all her symptoms became worse. She could not walk a single block, and was virtually bed-ridden; while her mind hovered on the narrow border-land separating sanity from insanity, she could not sustain a connected thread of conversation, and by her insane suspicions and conduct had alienated herself from all her friends and relatives. A vaginal incision was made and the ovaries reached, but they were adherent and could not be brought down. The operation was then continued by an abdominal incision just large enough to admit two fingers. All the signs of repeated periuterine inflammation were present. The ovaries were adherent to adjacent structures. The broad ligaments were very tense, and adhesive cords were across the pelvic basin, as tightly drawn as fiddle-strings. The ovaries being detached were cut away, after the ovarian ligament with its corresponding oviduct had been transfixed and tied on either side. The patient recovered promptly and seems much benefited mentally as well; her hallucinations have departed and she seems better in every way.

Case III. Was that of the daughter of a wretchedly poor Irish farmer whose insanity seemed to revolve around the ovaries as a storm-centre. The patient was a buxom unmarried girl of about one-and-twenty with the following history: For the past six years or ever since puberty, she has been insane at her monthly periods. At first mental aberration was noticed during the flow only, but now the fits of insanity begin a few days beforehand, increase in intensity during the flow and end a few days afterwards. For not quite two weeks of every month she is comparatively sane, although behaving very queerly and wandering about in an aimless manner. As she had not wholly recovered her reason since her last catamenial period at the time of the doctor's visit, she was found in bed, where she had obstinately kept herself for nearly two weeks. During that time she had not spoken a word, not even asking for food, but eating that which was

brought to her. To all questions she made no reply, but violently clapped her hands and screamed out at the top of her voice.

With this history of incomplete recovery between the menstrual periods, the decision to operate was reached with some hesitation. With the approval of all parties concerned the ovaries were removed and the patient made a good recovery. At the time this case was reported only a partial alleviation of the mental symptoms was obtained, but as a year had not elapsed it was hoped in the light of other experience that time would bring about a more complete recovery. The patient's surroundings, however, were of the most unfavorable character.

Case IV. This is not a case of removal of the ovaries, but is introduced to show the remarkable psychical influence sometimes exerted by them. A. B., single and about thirty years old, and a splendid specimen of physical development; had been in excellent health until a year ago her mind began to give way. She had no delusions, but she became melancholy and soon developed suicidal mania. For this she had to be watched night and day by the different members of her family. She has never had any disappointment in love nor practiced self-abuse. She has suffered from dysmenorrhœa though her catamenia have been scanty, and she has suffered from backache. Her bowels were constipated and a stool caused pain. The womb gave a measurement of three inches, and it was retroverted. Both ovaries were prolapsed. Each one seemed harder and rougher than natural, and the left one had a little boss on it as large as a grain of corn. After several failures a Hodge pessary was so modified as to keep up the womb and ovaries. A complete change took place. She lost her melancholy and her suicidal mania, appetite and sleep returned and she became well. Once in awhile the left ovary slips down behind the pessary and gets pinched by it, when the old symptoms at once return. She has now been taught the knee-breast pos-

ture and is able to replace the organs herself. She and her whole family are so convinced that the ovaries are at the root of all the mental trouble, that if this were to return, or if it were not possible to keep them in place, they would at once insist upon their removal.

DILATATION OF THE CERVIX UTERI AS A CURATIVE MEASURE.

BY EDWARD T. BLAKE, M. D., LONDON, ENG.

Artificial enlargement of the uterine ingress is still a new operation. It seems scarcely credible, that not half a century has passed away since the brilliant and original genius of Simpson made dilatation an integral part of legitimate surgical procedure. The neck of the womb had of course been dilated long before this time, but nevertheless, to that startling innovation is due the immense credit of showing that the cervical canal of the non-gravid uterus may be under certain conditions safely enlarged.

Simpson had long observed that maternity, when uncomplicated by sequelæ, was in a large percentage of women, a radical cure of their dysmenorrhœic distress. This sent his active brain to work to discover some certain yet safe method of imitating this beneficent result of motherhood. Many methods of dilating the cervix were tried, and a very curious success followed, not only did the dysmenorrhœa disappear, but occasionally sterility ceased with it.

Simpson was now able to add enormously to the palliative and curative means at his disposal. He found himself not only able to relieve the horrible recurrent sufferings of dysmenia, but to introduce curative materials into the uterine cavity; he could more easily modify a perverted position, and he could now with ease remove morbid growths from the wall and from the cavity of the uterus.

It would ill-become us to blame this great man, for for-

getting in the flush of the success this equally important fact, that as maternity often cures dysmenia, so it is quite equally true, that the pain usually in those who have borne no children disappears of itself about the age of thirty. Operations therefore conducted just before that epoch, for the relief of menstrual pain, do not always deserve the credit they may obtain.

It was probably as much from considering this fact, as from the frequency of cellulitis, following the use of dilators, that led Emmet last year to astonish the members of the Brighton Congress, by a sweeping and violent denunciation, of one and all those pieces of intra-uterine practice, that he had in former years done so much to popularize. Is Dr. Emmet afraid that his disciples have proved too apt as pupils, or is he beginning to reach the age when executive yields to caution? Already in his 1879 edition, he so hedges round the cases, where tenting is admissible, that one rises from the perusal of the passage, feeling that if in England one had to wait till all the needful conditions were present dilatation would indeed become a dead letter. For having premised that no cellulitis be present, he goes on to say that it must be a bright day, *wind in a certain quarter*, patient must not put her foot on the ground, the feet must have hot applications, the operation must be always carried out at the home of patient, etc., etc.

This I take it is a rather round-about way of saying, that the proceeding is always so fraught with peril that it is really inadmissible. As a matter of fact, I have, during a quarter of a century of very frequent use of tents, only once seen cellulitis follow the employment of that method of dilating. It was a badly gonorrhœalized cervical erosion. The tent was employed to get away a piece of chorion, no antiseptic was applied to it. I am of the opinion that if the head of the tent had been dipped in a germicide, there would have been no peril of producing cellulitis. For this purpose,

Eucalyptol is convenient as it does not swell the tent. Ethereal solution of iodoform has the same advantages.

If we know that the sponge is clean its head only needs antiseptic treatment, as that alone comes in contact with outer air.

I shall confine my paper to the question of dilatation of the non-gravid uterus. It will be convenient to consider the subject in its clinical aspect. The womb may be dilated for three chief purposes.

First. To relieve pain, tending to obviate sterility.

Second. To remove morbid elements.

Third. To introduce therapeutic agents.

For practical purposes the methods of dilating divide themselves naturally into two sorts, *vis*: Immediate and Delayed.

The latter operation still finds favor in the old country, and in Europe generally, the former or more modern operation, first performed in the States, appears to be preferred by American gynecologists, and for reasons I will presently give, has my sympathies.

Delayed or Mediate Dilatation is usually effected by introducing into the canal of the cervix, some expanding material, as sponge, sea-weed or soft wool, in a contracted form. Another method is to pass an empty soft rubber tube, to be afterwards slowly filled with water. On the latter principle are based the dilators of Barnes and Molesworth.

Immediate Dilatation is practiced in three ways.

First. Sudden or violent, it being intended that the cervix be ruptured to a certain extent.

Second. Forceful dilatation, where care is taken not to rupture the cervix.

Third. More delayed dilatation, which approaches in its nature the mediate method.

Dilatation with knife notching, will not be noticed, because it properly belongs to the domain of metrotomy.

The first method we need not discuss; most will agree

with Emmet that this is a proceeding to be admired for its daring rather than imitated for its wisdom.

Second. *Forcible Dilatation* may be practiced in a very great variety of ways, the most ordinary method is to use double or triple diverging metallic blades. I employ Palmer's Divergents, a most useful instrument. It may be much improved by having the tips much smaller, so that they may be made to enter a nearly stenotic os.

The three-blade dilator of Marion Sims is very valuable. Not, however, that the screw, which should be used only to rest the hand, has by some wrongly been made the dilating agent. This together with undue haste has led, in cases of friable cervix, to needless lacerations. I have employed them very largely and have never witnessed an approach to rupture.

Another way is to introduce a sheaf of guarded wires, something like a small closed umbrella. Within the wires a bulb is forced inwards, gradually thrusting the wires asunder like an opening umbrella, or after the manner of an urethrometer. This is known as Aveling's method; it is practiced at the Chelsea Hospital for Women.

Third. *Delayed Dilatation*. With the object of dilatation Molesworth's rectum-dilator is sometimes used. In the case of a miscarriage, where all hope of preserving the life of the fœtus is lost, and it becomes needful to clear the uterine cavity, this is the best instrument. It not only insures gentle and ample dilatation, but it entirely obviates the possibility of hæmorrhage.

The physician having applied this dilator, can with an easy mind leave the case for a few hours, certain that on his return with a Sims' scraper, or a Sims' spoon, he can get everything clean away. The mechanism of this dilator is very simple. A hollow finger of soft rubber, containing a pewter director, is passed well through the os, and warm water is forced within the caoutchouc cap, by means of a

syringe, or better, by persistent hydrostatic pressure from a well raised vessel.

The only drawback to this instrument is, that it needs very gentle manipulations, or it is prone to give way at a most critical moment.

All these dilators act from within out, by expansion. They are the most rational, because they imitate most closely the efforts of nature in the same direction; they are the most popular in the States. In Europe, bougies are more frequently employed. When used properly, that is with the cervix fixed, they are certainly safer in unskilled hands, than those of the former group. The favorite form of bougie at present is that of Prof. Hegar of Freiburg. They are simply bent ebonite cylinders, ending with a blunt cone, furnished with a small handle, marked with the respective diameters of the transverse sections, from one-twelfth of an inch to one inch in length; length about three and one-half inches. There are some much thicker for rare emergencies. The diameters differ successively by half a millimetre.

Tents of all kinds are certainly falling into disuse in all schools. But for one purpose they are invaluable. That is, in getting away multiple young polypi, and in removing the villi in a case of endometritis papillosa.

For the purpose of dilatation pure and simple, I have personally abandoned the use of tents. My chief reasons are: First, because their action is tedious, involving many procedures where one would suffice. Second, their use is horribly painful. Third, cellulitis may be induced, or latent, may be lighted up by these.

A CASE OF FŒTAL DEATH WITHOUT DECAY.

BY M. W. VANDENBURG, A. M., M. D., FORT EDWARD,
NEW YORK.

On the morning of March 8, 1887, I was called to see Mrs. M., primipara, 26 years old, in excellent health, and a

woman exceptionally well educated and intelligent. She had sustained a slight discharge ex-vagina, a half hour before, of a reddish watery fluid, about a quarter of an ounce in all, accompanied by the thick mucous plug that always betokens coming events. Examination revealed the cervix uteri well down in the pelvic cavity, and a soft tumor the size of a large acorn protruding. There had been little or no pain. At first it seemed puzzling, but a little closer attention showed plainly it was the unruptured membranes protruding from the os. No foetal parts could be made out through the membranes or the uterine walls; the odor of the thin, scanty, watery discharge was normal, while any checking of the labor was plainly out of the question. This was now a little past the thirty-second week. She said she had felt motion, but this seemed doubtful. For the past two months there had been very little increase in the size of the abdomen. Her health and physical state generally had during this time been exceptionally good.

On the present occasion, pains, so slight as to be barely noticeable, recurred about every ten minutes.

The sack slowly enlarged, and when at the end of an hour and a half it had reached the size of an average orange, the membranes were ruptured, the patient sitting on the chamber vase. Some difficulty was experienced in accomplishing this result, though the index nail was sharply notched. The membranes were unusually tough and resisting.

A slight gush followed, and when the vase was removed, it contained six or eight ounces of grayish, reddish, porridge-looking fluid. With the eyes closed, I should have called the odor of the examining finger perfectly normal.

On resuming the recumbent posture, a still more puzzling phenomenon appeared. A long, rigid, irregular umbilical cord seemed to fill the vagina. Finally an end was found, and that settled matters. By gentle traction a long cord-like limb was brought out, then a second, then a flaccid, bladder-like abdomen, filled apparently with fluid, and not much larger than

an egg, then a thin, small thorax with wiry ribs, and here matters rested. The head was still in the grasp of the uterus. Finally with one or two slight pains it came away, entirely collapsed. The placenta remained with the umbilical cord attached. Traction, combined with pressure over the uterus, was gently used upon the cord, and it proved to sustain full as much force as a normal cord at full term. After a short time the placenta was removed entire, and the whole taken to an adjoining room and examined. The fœtus was about ten or eleven inches long, the head and abdomen both completely collapsed, the limbs about the size of a small umbilical cord, watery, bluish pink, with some resistance of bone, the toes and fingers indistinctly absorbed, the whole very flaccid. The placenta looked bluish, pale and bloodless. To no part was there the slightest odor of decay, and the membranes, as already said, were remarkably tough.

The woman herself was in excellent condition as regarded the state of the uterus, with only moderate flow and good contraction. On the second day the flow was scanty and of bright, deep-red color. She manifested no symptoms of fever, and had a normal appetite.

About ten weeks before the abortion, the patient had accidentally spilled some hot syrup on one of her hands while at the table, and burned two or three of her fingers quite severely. This was the only history of shock or trouble of any sort that could be elicited.

It seems very probable that the child, not over-strong at first, received a shock that caused it gradually to pine away and absorb or lose flesh until it was scarcely more than skin and bones left. In the cremation of the fœtus quite a number of the bones, even of the ribs, withstood a white heat and did not crumble when cooled down. Did this fœtus keep up a low form of circulation and vitality until just previous to the abortion, or had it been dead as to circulation from the time of the shock or soon afterward? I must confess I can not answer the question to my own satisfaction.

But the case may throw some light on those instances of retained foetus, that have been carried in the abdomen for years, and have often become ossified.

The recovery was rapid, complete, and a few weeks sufficed to bring the mother to normal health.

NON-SPECIFIC URETHRITIS.

BY GEORGE F. FORBES, M. D., WEST BROOKFIELD, MASS.

(Read before the Massachusetts Surgical and Gynæcological Society.)

Unfortunately I have been called upon the past few years to treat this disease much oftener than is desirable for my own credit or the credit of homœopathy. I have been through what may be called an epidemic of urethritis. I consulted my own library for authorities on this subject, and found I had none. I ordered the best book from the pharmacy, and received the reply that "there was nothing in homœopathic literature treating on this subject." I ordered something from an allopathic stand-point, and was told that Dr. Skene's book on "Diseases of the Bladder and Urethra" was all there was to be had. I at once ordered that, and found that Dr. Skene's book "had gone out of print." So, Mr. President, I come before you in a wholly original form to-day, and may crave the indulgence of the members if this paper is short, fragmentary and uninteresting; simply remarking that here is a magnificent field of homœopathic literature left entirely free and unoccupied, to some member of our society! Who will improve this opportunity? I console myself that what little I may say will have an original merit, if no other.

Among the causes may be mentioned the effects of a cold, stricture of urethra, horse-back riding, uterine tumors and displacements, acridity of urine, leucorrhœa. But in my experience, by far the most frequent cause is nervous or spinal

irritation of the extremities of the sacral nerves. Indeed, I have rarely found cases in the chronic form where the cause was not attributable to nervous irritation and, directly or indirectly, inflammation or irritation of spinal nerves. For this reason those women afflicted with urethritis, where the cause is spinal irritation, are generally troubled with insomnia, and are consequently as great sufferers at night as by day. If the uterus be prolapsed or anteverted, there is of course greater aggravation of the difficulty when the patient is standing, and relief when lying down.

In hysterical or nervous women, we shall notice after a paroxysm of strangury an abundant flow of pale, limpid urine. In cystitis, on the contrary, we have marked constitutional symptoms, such as a chill, fever, anorexia, rapid loss of strength, feeling of distension of the bladder, burning sensation, more especially of the rectum, and, in the advanced stages of cystitis, we very readily differentiate between that and urethritis. In the first edition of "Ludlam's Diseases of Women" we find these words: "It is a singular fact that most writers on the diseases of women have said little or nothing of this painful affection. We cannot attribute this oversight to its infrequency, for, in the female subject, urethritis is much more common than stone in the bladder, or cystitis." There is no disease which is at once capable of, and actually does, produce more suffering, disgust, and misery than urethritis, of the non-specific variety.

"Very extreme sensitiveness" has been noticed by Dr. Galabin, an English authority, in his "Diseases of Women," who also asserts that "any cause of passive hyperæmia also tends to promote it." There is pain on micturition, often extreme, and inflammation and sensitiveness so excessive that even walking is very difficult. We sometimes see granular inflammation of urethra extending nearly its entire length, especially in old women, the surface being red and sensitive. Galabin advises the repeated application of a strong solu-

tion of nitrate silver, or carbolic acid and glycerine (40 per cent). Now it is an established fact that all secreting organs and tissues are liable to become vitiated when operated on by unnatural stimuli. The lining membrane of the urethra is subject to the same laws as the mucous membrane of the throat, lungs, bronchi, palpebræ, etc., all becoming inflamed by morbid secretions according to the morbid causes which have for a greater or less length of time been in operation. Urethritis may become a sequela of acute or chronic rheumatism, gout, exanthematous fevers, acute or chronic catarrh.

As to treatment I have been unable to cure any of these cases with the single dose of high or low remedy, be it ever so well chosen.

I have been perplexed with these cases for many months, sometimes years elapse before I can see any improvement. In general, it may be well to say, we should avoid indulging or favoring the conditions which gave rise to the disease. If from overtaxing the spine or the nervous system, rest in the best manner the patient can rest, usually in the prone position. If from catarrh of the bladder injections into urethra of glycerine and vaseline or hydrastis and olive oil, or hamamelis and arnica have proved beneficial. When operating we have an excellent opportunity to ascertain whether there be stricture of urethra or stone in the bladder, and treat accordingly.

In nervous urethritis, or when it is caused by irritation of spinal nerves, we shall find application of hot water to the sacral region and external genital organs as well as rectal enemas of hot water relieve as quickly as if applied to the vagina or urethra. In nervous urethritis one of the best palliative means I have tried is a rectal enema of a quart or more of hot water, beginning with as hot as can be borne and constantly adding hotter water until the temperature is at 110 or higher. I have sometimes found apis tinc. 10 drops to a quart of hot water relieve better or quicker than clear

water, especially if the pains or sensations were of a stinging character. In case of stricture or cystocele I apply glycerine and tannin with tampon within the vagina, also advise to urinate quite often, and when possible to lie on the abdomen. Shüsler's magnesia phos., equisitum, apocy., can., and gels., in some cases have given relief. Two or three typical cases from practice may serve to illustrate the difficulties experienced in treating these cases and perhaps provoke some criticism—if so I shall be content.

Case I. Mrs. M., aged 65, neurasthenic, mother of three children, has suffered for some twenty-five years with neuralgia in various places, until within the last ten years she has had neuralgia and inflammation of urethra extending from the meatus into the bladder and to the ureters, sometimes to kidneys. But there has been during all these years almost constantly an excruciating pain through from urethra to os coccygis. Sometimes there has been catarrh of neck of bladder, but mostly there has been unbearable neuralgia from non-specific urethritis. During these twenty-five years I have prescribed oftener than any one else for this woman. Sometimes I have treated her one or two years continuously, but all medical aid, or local appliances, or surgical interference I have as yet exhibited have utterly failed of a cure, though many times they have proved palliative. Dilatation of urethra with bougies and tents sufficiently to admit the little finger would invariably relieve for two or three days at a time. Application of cocaine ointment 5 per cent. would relieve for a few hours only, so will unguent morph. or bromide potass., relieve temporarily. Hypodermic injection of morph. will relieve, but this she is opposed to as she is also to the opium habit; she would doubtless have buried all such scruples in her paroxysms of pain, if opium had agreed with her. There are no symptoms pointing to stone. There has been during most of these years an inability to retain the urine for more than one or two hours at longest, and when it is passed, the pain is violent for several minutes.

There is no appearance of ulceration along the course of the urethra, no discharge of pus remained on the tents employed, there has been seen several weeks together a thin, whitish, catarrhal mucus oozing from the urethra, but no pus. Besides the topical remedies mentioned I find at. 3x, ac., canth., can., merc., the best internal medicines, but as I said before I find only palliation instead of cure as I have hoped. Other doctors becoming discouraged with the case, she invariably resorts to her first love, and I again proceed with the case as of yore.

Formerly there was anteversion, but the womb has now remained in its normal condition for years.

Case 2. Miss H., aged 29, dark, bilious temperament, thin in flesh, non-hysterical, had catarrhal fever about two years ago. After running its usual course it resulted in two months time in acute urethritis from catarrh of the bladder and its neck. In spite of my best efforts to cure this case, I fear it is destined to assume the more chronic form, and the terrible suffering of the first case mentioned. Already there is intense suffering if urination is prolonged more than one or two hours, and often she is obliged to urinate once in a half hour during the night as well as during the day. Dilatation of the urethra relieves, like the first case, for a few hours only, and the same appliances as before mentioned and the same medicines exhibited failed to effect a cure. Iodoform and eucalyptus urethral suppositories relieve the excruciating pain for a little time, but the strangury is sure to return in a very few hours. I can find no gravel or stone in the bladder with the sound, and no abnormal appearance of the meatus. The usual tests of urine reveal nothing definite, and there seems to be nothing abnormal but the catarrhal inflammation, and irritation of spinal nerves.

Another case I will recite, varying somewhat from the other two, but presenting many of the characteristic symptoms of non-specific urethritis.

Mrs. S., widow, 40 years of age. Had one child at 25

years of age, had anteversion and for many years following; was troubled constantly with excoriating leucorrhœa, superficial ulceration of the os uteri, hyperplasia of os [(?) Ed.] and cervix, with catarrh of bladder and urethra.

All these diseases were successfully managed with various external and internal appliances and internal homœopathic remedies, so that this woman has fulfilled her mission in rearing and educating her boy, and at the same time doing a power of work for her family in general.

I am now treating her for urethritis caused partly by catarrh of the bladder aggravated by overwork of her brain and nervous system. There is constant irritation of the vulva, constant desire to micturate when the least excited, urine scalding, with sharp shooting pains when nearly through the act, lasting for several minutes. At night during sleep there is no trouble in this case, or call to urinate, but the moment she wakes there is a loud call with the usual pain described. I learn the leucorrhœa which we thought entirely cured five years ago has returned, and she has also a partial return of all the old troubles. What the final result in this case will be I am at a loss to determine, but presume she will some day recover, if she does not go hence with something else sooner. But the inflammation of the urethra causes much pain, anxiety, disgust, and distress. If some one will suggest a cure for the cases, I shall be his friend forever; or if some member will write a book on this subject I will engage the first dozen that are published.

DYSMENORRHŒA—SOME OF THE CAUSES OF THIS MOST PAINFUL ILLNESS.

BY D. B. WHITTIER, FITCHBURG, MASS.

In preparing this paper it is not my purpose to prepare a treatise upon this subject: repeating text-books already

published, enlarging upon those copied from, by quoting from others: puzzling my brain to arrange it so it will appear really new.

As I have from time to time heard papers read, and the subject discussed, trying to solve the mysteries of this difficulty, I am prompted to state a few original ideas.

There have been cases that were considered incurable (we will except the statement of those who always cure everything that comes in their way). But to the majority of us we often meet more than our match.

Is it not possible that if we better understood the *causes* could there not be more cases cured? Have not some of the causes been overlooked? And where remedies have failed as administered, might not some other means be resorted to that would give relief? It is well-known that the larger number of these cases are caused by debility, that by restoring the general health the difficulty will be removed.

There is no doubt that many ladies are subjected to examinations, compelled to wear instruments of torture, when, if a little common-sense had been used and the general health of the patient properly attended to, all would have been right. But all cases cannot be attributed to general debility, and it would be a serious mistake to treat all cases in this way. There are a small proportion of cases that must be treated differently. And to urge the necessity of a careful investigation of the cases presented to us for treatment is one object of this paper. I know of no better way than to refer you to a few cases of so-called incurable dysmenorrhœa :

Case I—Mrs. A., age 22 or 23 years, suffered most excruciating pain, could take nothing that would give relief. Her general health had been attended to; had taken the many vaunted cures from the best to the worst, still received no benefit. She would take a tumblerful of brandy, without being affected by it or receiving any relief; would

take laudanum by the teaspoonful, and still suffer. I resorted to hot baths, mustard, and the like, still of no avail. Finally she applied for treatment and told her story. An examination was proposed and strongly objected to. Therefore we prescribed the best remedies to no avail. After much more suffering she consented to the examination, which revealed the cause of her suffering. The parts were in a nearly normal condition, the womb being somewhat enlarged excepting at the mouth. The whole of the inside as far as could be ascertained showed that the papillæ were hypertrophied, and a mass of soreness, bleeding at the slightest touch. Had the appearance of "erethritic granulation."

The cause of suffering was the menstrual fluid passing over this sensitive surface, together with the papillæ being in a hypertrophied condition. The passage was obstructed and very sensitive. It was easy to account for the extreme suffering and for failure of remedies as administered.

Without an examination this doubtless would have been reckoned an incurable case, but by it was easily cured—which was done by cauterizing the diseased parts for a few times and the other required treatment.

To illustrate still farther—another one of the incurable cases applied for treatment, where medicines had failed to relieve. A careful examination revealed just inside the os a small growth about the size of a pea, which tended to obstruct the passage. The growth was removed and the distressing dysmenorrhœa cured; and many other cases might be referred to, which, with proper examination and management, were cured, even where the suffering had been for years making a regular "drug shop" of their stomachs.

The many cases caused by displacement are too well known and understood now to refer to by name. We are of the opinion that as these cases become better understood the number of incurable cases will be lessened or entirely wiped out. Let us study and hope that ere long incurable cases will be something of the past.

A CASE OF SPONTANEOUS EXPULSION OF
FIBROID TUMOR OF THE UTERUS.

BY CHAS. M. FULLER, M. D.

(Read before the Mass. Surg. and Gyn. Society.)

The case I have to report is one of spontaneous expulsion of fibroid tumor of the uterus.

Oct. 28, 1886, was called to see Mrs. N., a slight-built, dark eyed woman of nervous temperament.

She complained of intense backache with bearing down pains—there was also much pain through her limbs, especially through the thighs; she was very much nauseated, vomiting almost everything taken into the stomach, the slightest movement would cause vomiting; there was also a very severe headache, pain in occiput which extended over the vertex and into the left temporal region; the whole scalp was sore, the slightest movement caused an increase of the pain; was not disturbed by bright light. Her bowels were much constipated; indeed, she had suffered from this for a number of years; there was great tenderness over the abdomen, which was aggravated by touch and movement: the urine was scanty, of a dark color, and passed with difficulty; she had felt for the previous two or three days that her menses would appear, although she had been very irregular in this respect, they usually appearing once in a fortnight and being very profuse and painful. This time it had been six weeks since her last sickness; she had a copious discharge of dark-colored leucorrhœa which was very offensive. She had no appetite, suffered much from thirst, but drank very little, on account of the nausea. Her strength was but little, she became easily tired, it was very hard for her to get about the house as she was unable to walk on account of a spinal trouble; still she manages to do quite a large amount of work. She has one child eight years of age, at whose birth she suffered very much, the labor being very tedious.

As there was great tenderness about the genital organs no examination was made, I prescribed gelseminum for the headache and caulophyllum for the bearing-down pains. Friday the 29th, the patient was not much improved, although the headache was a little less, the pains through the back and limbs were fully as severe—the nausea still persisted; her temperature was but slightly above the normal, pulse, 84 per minute. She had taken but little nourishment, that in the form of gruel and beef tea—had rested but little the night before. I continued the prescription of the day before with an occasional dose of ipecac. As the leucorrhœa was very profuse and offensive, ordered a vaginal injection of carbolized hot water, to be repeated every three or four hours. Saturday morning found my patient somewhat better than the previous days; she was flowing a little—the flow was intermittent and of a dark color. The headache was not as severe; the pain in back and thighs still continued as did the thirst and nausea. Prescribed as the day before: At 11.30 P. M., Saturday, was called in great haste: her husband who came for me saying he thought his wife would die before I could reach her: I found the patient almost bloodless: she was flowing profusely, about all the available cloths were saturated with bright red blood; she was much nauseated and with every attempt at vomiting the blood would gush forth in a stream.

I immediately had the foot of the bed raised and administered brandy and water as she frequently approached syncope. Prescribed ipecac and china. The bearing-down pains were severe. There was much tenderness over the abdomen and about the genitals. On digital examination, which was made with difficulty, found the os uteri dilated to the size of a silver quarter, the anterior lip somewhat thickened, the posterior attenuated. There evidently was a growth of some kind either within the cervix or just above the internal os that had encroached upon the posterior lip, making its walls thinner. All efforts made to dislodge the

growth were unavailing as I could not get my fingers behind it. The bearing-down pains still continued, as did the flowing, which however became again intermittent. The nausea was exceedingly annoying. She also complained of a very severe headache at the base of the brain which I thought due to exhaustion caused by the loss of blood and rest, she not having slept as well for the previous fortnight. I remained with her through the night, and by constant application of remedies, internal and external, succeeded in arresting the flow in a measure: it became darker and somewhat clotted. At 8 A. M. Sunday, when I made an examination, found the os dilated to the size of silver half-dollar and filled with a substance that closed the outlet of the uterus. As I could not dislodge the mass which seemed quite firm and hard, administered a teaspoonful of fl. ext. of ergot, to be repeated in an hour; then left the case, giving directions in regard to use of remedies and stimulants in case of an outbreak of excessive hæmorrhage. At 1 P. M. was again called, the messenger leaving word the patient was in great pain; being away from home, did not reach the bedside of my patient until 3.30 P. M.; found her quite comfortable. The pains which for a time were less began to increase about 11 A. M., and became very severe between 1 and 2 P. M., when, after a very severe pain that seemed to continue for several minutes, something was expelled from the vagina, followed by a copious discharge of blood. After a few pains that were comparatively slight the flowing ceased and became merely a bloody discharge. All the symptoms except the headache were relieved.

Upon examination of what had been expelled, found what seemed to be an enormous clot which, being wiped away, revealed a hard globular substance about as large as a medium-sized orange. It was enveloped in a membrane, and on being cut there seemed to be layers of tissue arranged as in an onion. The cut surface was of a pinkish white that almost glistened.

One side of the tumor was lacerated ; the enveloping membrane was torn off as if it had been forcibly torn from its bed. The greater part of the external surface was comparatively smooth.

Unfortunately, I was called from this case in haste. Returning for my specimen found it had been thrown out by the nurse. This I very much regretted as I should like to have examined it more thoroughly as well as to have had it to present before this society.

After the expulsion of the growth the patient improved rapidly in most respects. Her strength came rather slowly and the headache persisted. The treatment was such as would be indicated in a case where there had been a great loss of blood, accompanied by excessive nervous prostration, *viz.*, china, phos. ac., nux vom., ignatia, arsenicum, etc. She had also iodine, conium, ergotine pills (Globe), the latter remedies being given as by examination other growths supposed to be fibroid were found.

The early history of the case showed that three years since the patient was walking on the street with a crutch and cane (her spinal difficulty rendering her unable to venture out without these supports) when she was rudely jostled by a man running against her ; she fell to the sidewalk, striking the lower part of her back against the curbstone ; she began to flow at once and continued so to do for two weeks after this mishap ; she became very irregular in her menstruation, which was very painful and profuse. There was persistent pain in head and back, bearing-down pains, constipation and a train of symptoms have followed until this time, for my patient is by no means cured. Did the fall have any bearing on the causation of the tumor ? I hope the case will be freely discussed, and that it may draw out some points of interest in the etiology and treatment of fibroid tumors.

DYSMENORRHŒA.

BY DR. WHITTIER, FITCHBURG, MASS.

The life of women is a life of traumatism, consequently the majority of women suffer more or less with dysmenorrhœa. Since its continuance results in changes usually ascribed as causes, the study of this disease primarily as well as secondarily is important to the general practitioner as well as to the specialist.

The investigation of this subject is attended with much difficulty from the nature of the complaint and also from the fact that it affects chiefly the unmarried and childless women. Sterility adds to its pangs. Allusion need not be made in detail to complex conditions, but a few general statements which point to physiological defects as well as pathological facts may be sufficient to lead to the investigation and recognition of the complexities in most cases.

Dysmenorrhœa is primary or acquired; the former appearing at puberty and if continued, indicates physiological defects like the imperfect development of the genitalia; an impoverished nervous system or hereditary conditions which obstruct healthful development and chain the ills of parents to the life of the girl; to eradicate or ameliorate these conditions so that the secondary will not obtain, will require the acumen of the physician through the exigencies of girlhood to maternity. The pathological changes resulting from dysmenorrhœa constitute the secondary or acquired. The more common of these are slight uterine hypertrophy, erosion of the mucous membrane of the cervix, catarrh, abnormal changes in the menstrual flux, ovaritis, anæmia and a possible peri-metritis. The hypertrophy results from increased muscular action, from spasm, flexions or in the expulsion of shreds of decidua, clots and mucus. These secondary conditions are often regarded as the causes of dysmenorrhœa rather than as the results, and it is usually in this stage that the specialist is invited to the care of the disease.

Therefore, to determine *what* results had followed the primary, the specialist is in duty bound to examine the reproductive organs by digital touch or specular inspection that he may treat the case intelligently and successfully.

Remedies for the primary state are calc. phos, mag. phos., kali phos., with nutritive and general hygienic measures. These three remedies if used properly will secure good results. No one need think it an easy task to prescribe Dr. Schusler's medicines. The secondary conditions beside constitutional care require such local treatment as each specialist's experience determines.

EDITORIAL.

Topical applications of the uterine cavity, or intra-uterine medication, is a subject of vital importance to us as a distinctive school of medicine, and one so little appreciated by the masses of the homœopathic practice that we are constrained to attribute its disparagement to one or more causes, which, if properly understood by the intelligent members of the profession, might be construed other than to its disadvantage.

The study and practice of gynæcology is without doubt one of the most fascinating and interesting departments of medicine or surgery known in the whole range of medical practice, and yet, owing to the empirical nature of the knowledge obtained, it places the observations and the information of its practitioners at such variances of conclusions that often a single subject, like intra-uterine therapeutics, will have reported seemingly opposite results.

In our school the question of intra-uterine therapeutics reaches more than ordinary interest, as the majority of its practitioners, to-day, use the orthodox treatment because of the overwhelming influence of the literature of gynæcology forced upon us by the dominant system of medicine, headed by Thomàs, Mundé, Goodell, Sims, not omitting the late works now in type, as the American System of Gynæcology and the Cyclopædia of Obstetrics and Gynæcology. Is it to be wondered at that our practitioners, who have been taught gynæcology in their respective colleges, or worse,

in some allopathic (alias, Scientific Medicine ; alias, Old School ; alias, Regular ;) medical college, is it to be wondered at, we say, that their methods of treatment will be more empirical than scientific ? Many of our so-called homœopathic physicians in their topical applications to the mucous membrane of the uterus even discount their brother allopaths in employing methods that are now entirely a thing of the past. The fault of this condition lies largely within ourselves, and must continue so until our system of teaching gynæcology becomes more in accordance with our well-known law of therapeutics. It is wrong to teach a class of students in a college recognized as a homœopathic institution, that it is proper to treat a case of endometritis with an application to the mucous membrane within the uterus of a strong caustic of solid nitrate of silver, by the *porte caustique* of Simpson's method ; by an application of strong nitric acid as now employed so universally in England, or by the later more fashionable applications of carbolic acid (full strength) or iodophenol—an escharotic, in full strength—or by iodine—another irritant to mucous membrane—and last but not less severe, by the *ecouvillon* or mop which is in vogue in France. This treatment consists in passing a soft brush gently over all portions of the intra-uterine surface, removing all débris without injuring the mucous membrane. The blunt curette is also popular in some portions of Europe. But even with this great weight of evidence against him, there comes a Moses from out of all this dark age of gynæcology in the allopathic ranks, whose noble example should be followed by our practitioners. Be it said, to our shame, that an allopath was the first to discontinue local applications in uterine disorders. Recognizing the three features of gynæcological practice, the first, embraced under therapeutical treatment, the second, palliative, and the third, mechanical, he devotes his attention to the first with an honesty of purpose that would bring the blush of shame to the face of the average homœopath in his treatment of the ordinary cases of a gynæcological practice. Dr. Emmet, the *beau idéal* gynæcologist of America and for that matter of the world, had the moral courage to place himself on record, before the British Medical Association in the following language : “ Holding the views I have so long maintained in relation to the cause of the discharges from the

uterine canal, it followed that I abandoned early the practice of internal applications, and I believe that I was the first to do so. During the past seven years I have not made, in ordinary practice, an application of iodine within the uterine canal, and had, to a great extent, abandoned the practice sometime before. I may now state that I have long since reached a point in practice where I avoid, if possible, the introduction of any instrument or remedy within the uterus."

This example is rapidly being followed by many American gynecologists, especially the younger class ; while some, like Mundé, Thomas, Bozeman and Goodell, still believe in the old tincture of iodine treatment. The question of cause of uterine disorders has now become a question of so great importance that the subject of intra-uterine therapeutics must be held in abeyance until the ætiology is established beyond doubt. The solution to this problem, so far as it relates to our school, must necessarily be left to the teachers and writers whose duty is so manifest that any violation of its principles should be met with proper condemnation and reproof. The day has passed for imitators and slipshod work in the department of gynecology, and the man who so far forgets himself in this branch of medicine as to teach " things of the past " should be relegated to the chamber for antiquities and classified with other relics of barbarism. The motto should be *progress in uterine therapeutics*.

EDITOR'S TABLE.

DEAR EDITOR :—In the last number of your valuable journal you have caused me to over-react myself. I refer to the published proceedings of the last meeting of our (Michigan) State Society, and especially to my "alleged" article on *Suppressio Mensium*. The remarks made by me at that meeting were entirely extemporaneous, the stenographer, a non-professional, never having before reported the proceedings of a medical society. I am naturally a rapid speaker and you received what you supposed to be a verbatim report, publishing it as such. I know, my dear sir, that you have been having a hard time of it physically, for which affliction you have my heartfelt sympathies. I know, too, that your position affords many curses and few emol-

uments. [How true.—Ed.] It nevertheless strikes me that the only journal we have in our school devoted entirely to Obstetrics, Gynæcology and Pædology should not permit such palpable blunders to appear in its pages, as occur in the July issue. It strikes me that *some one* on the editorial staff should take enough interest in even "society proceedings" to prevent the writer or speaker from appearing "to mouth his words." Let me point out a few of the mistakes which are inexcusable, but making the author appear, nevertheless, ridiculous: "The symptoms vary from the slightest malaria" [malaise] "to the severest convulsions"; "puriform" [pyriform] "shape of the uterus"; "absorption of puratic" [pleuritic] "secretions". In discussing "balottement" as a sign of pregnancy the word was evidently too great for the lady stenographer, so she left it out entirely, and after mentioning that "peculiar pink tint" of the vagina as a sign of pregnancy she becomes utterly at sea, and continues: "You get them with calculi and antiflexio-uteri; and again in the uterine souffle, when the fundus may fall back upon the finger in such a way as to indicate pregnancy." Oh Lord! What have I done to be thus sorely afflicted!!

I was requested, after closing my remarks, to give the reporter the names of the remedies mentioned. I gave her the little 2x4 slip of paper upon which I had hastily written a few notes. They were thus reported to you and you in turn publish them as given, a veritable digest of digests—a *multum in parvo* indeed. In short, Mr. Editor, the whole article looks as though the report first passed through your hands uncorrected, went to the devil, and did not come back again until it came through the bindery. I wish that his Satanic Majesty had kept it. My only recourse is to pummel you. Perhaps you can get some satisfaction out of the gentleman referred to.

Yours very truly,

JAMES C. WOOD.

Ann Arbor, Aug. 10, 1887.

[Although it has been our established rule, since occupying the position of editor, not to notice any personal correspondence or criticism except by and through the editor who, if he thought proper and in justice to the writer, would offer an explanation, the above complaint is so apropos of the subject which we had in mind for an editorial, that we are disposed to print the letter entire, aside from the irrelevant matter, and explain our share in the last number (July).

Publishing a medical journal is not unlike, in many respects,

publishing any other form of information to the public, newspapers, medical books, etc., etc.; but, different from any other publishing business in the world to this extent; the subscribers and contributors think they have a personal claim upon the editor and publisher and if anything goes amiss:—an editorial that does not please them—or, if the printer, under the supervision of the proof-reader, makes a typographical error; or if *space* was improperly made, the editor is held responsible. Doctor Wood complains of the associate editors, stating that “some one on the editorial staff should take enough interest in even ‘society proceedings’ to protect the writer.” Very true, but when said “staff” were not called upon by the publisher—the editor being not only sick in bed, but unconscious for nearly two weeks with cerebral hyperæmia, a prisoner in his own house, the writer of the above will at once understand our situation; and, too, the publisher, Mr. Chatterton, being in Europe, will still further explain why the July number was not mailed to the subscribers in as good editorial or mechanical form as in the past. We might, in justice to ourselves, complain that the obituary of Professor Schroeder was not only consigned to the last page of the journal, but set up in small type instead of occupying a place in the body of the journal. We again might enter a complaint that our leading editorial on the American Institute was given space as a letter from *Philip Porter*. We, with Doctor Wood, might add, “Oh Lord! what have I done to be thus sorely afflicted,” but as an editorial life makes one somewhat philosophical, we have now adopted this rule: If disappointed in the “make-up” of an article, remember that others suffer likewise, and the less you call attention to the matter the sooner it is forgotten. If you feel like scalping the editor—he is only human like yourself—write him a long letter full of tirade and abuse, winding up with the following sentence: “I shall expect this communication to be printed in full and the proof sent to me for correction.” If the average writer—there are many exceptions—of medical articles could see his paragraphs and words set up *as they came to the editor*, without any correction, his cry of complaint would be couched in language more forcible than polite. The editorial work on a medical journal is a luxury, made so by the salary and

perquisites that are always associated with the position. Still there is a bright side connected with our work that even critics and fault-finders can not disturb, and that is, letters of commendation, encouragement and congratulation of the labor performed by a worried and exhausted editor, which are like an oasis in the desert to the weary eyes of the tired traveler. Of course letters of this character are scarce, but nevertheless, they are appreciated by those whose only reward is usually abuse. We accept Doctor Wood's communication in the same spirit it was sent; a perfectly justifiable criticism, one that we are always willing to receive and if possible correct the mistakes.

The moral of the above is this: while it is not necessary for a writer to belong to the pachydermatous class, still he should be prepared to see his pet article mutilated and the language, in type, so foreign to the subject, as prepared by the author, that he may feel thankful that his lines are not set up in the Hebrew or some other classical language.]

—We are enabled to present with this issue a review of Vol 1, of the American System of Gynæcology. The current year has probably brought forth more gynæcological and obstetrical literature than any decade before and the contemporaneous gynæcological treatises cover the ground so thoroughly that many years must elapse before occasion will again arise for the publication of so extensive gynæcological works. The "Cyclopædia" of Wm. Wood & Co., while a complete record of the labors of representative men abroad, contains but little more than notes of what has been accomplished by Americans. It is therefore exceedingly proper that gynæcological and obstetrical history should be perfected to date by the embodiment of those subjects, in which American medicine has won its greatest triumphs, in the purely "American Systems of Gynæcology and Obstetrics." Candidly speaking, while there cannot but be some repetition in two so extensive cyclopædias, each work is but the complement of the other and to keep abreast of his fellows the modern gynæcologist will find both a requisite of his library.

—PULTE MED. COLLEGE.—"Owing to ill health Prof. M. M. Eaton of Cincinnati has been compelled to relinquish his college work as professor of gynæcology. The board of trustees have selected Dr. Philip Porter of Detroit to fill the vacancy."

The editor takes this opportunity of thanking all those who have so kindly "noticed" his new relations, and assures one and

all that the old and honorable institute of medicine, the PuSte, will ever extend them a warm grasp of the hand of welcome should they ever make its lecture rooms "a call."

—Metho-Glycerole of Bismuth and Hydrastin is a preparation made by Chapman, Green & Co., of Chicago, and consists of the liquid bismuth, glycerine, and hydrastin (white). This compound is one of the most efficacious in the treatment of vaginal erosions—follicular in nature—we have ever employed. The direction for topical application is to reduce, with water, one half, but if the patient is not susceptible to the action of the glycerine, this is unnecessary. We use it full strength. The vaginal irritation that is found so often in Douglas's cul-de-sac, and yet seldom seen by those physicians who employ a bivalve speculum in examining their patients, responds readily to this mixture. We order a tampon of cotton or wool saturated with this solution, introduced every night and morning, but caution the patient to remove the tampon after two or three hours. It is injudicious treatment to allow a tampon or any foreign substance to remain within the vagina for any length of time as the presence of the tampon dilates the soft parts and the vaginal canal not only becomes relaxed but soon fails to support the uterus. We have seen cases, after a thorough treatment by tampons of cotton saturated with glycerine mixtures, in which the tissues had relaxed until the vaginal canal was simply an inelastic bag affording but little support to the uterus. When the employment of a pessary becomes absolutely necessary, its presence is of course mechanical in nature and must be tolerated; but even in these cases the instrument should be removed as soon as practicable, every night. The mixture of metho-glycerole of bismuth and hydrastin, may be employed with the vaginal atomizer. If it causes a burning sensation, as with some it does, add as much water as you have solution which will relieve the smarting. In reference to tampons, employ as small a size as possible and then remove within two or three hours.

—We desire to call the attention of our contemporary *The Archives of Gynecology, Obstetrics and Pædiatrics* to the fact that our journal has, in its title, the "sectarian" designation *Homœopathic*. The two articles abstracted from our pages, which we find in the August issue, are credited to the *Journal of Obstetrics*, a publication with which we do not wish to be confounded and which certainly should not receive credit for our work.

—Wm. Wood & Co., publishers of the "Encyclopædia of Obstetrics and Gynecology," desire to call attention to a fact that will allay any disappointment in the regularity of the appearance of the

volumes. It has been found convenient to issue the volumes as rapidly as they come from the hands of the translators and editor without regard to their consecutive numbers. Vols. 1, 2, 3, 4, and 6 are now out. Vol. 5 will probably be the last one issued, in consequence of about half the volume being entirely original by the editor, Dr. Grandin. Vol. 10 will be issued this month, Vol. 9 in July, Vol. 7 in August, and Vols. 8, 11, 12, and 5 in September and October, completing the work.

ORIGINAL TRANSLATION.*

A NEW TREATMENT OF CHRONIC METRITIS AND IN PARTICULAR OF ENDOMETRITIS BY THE INTRA-UTERINE CHEMICAL GALVANO CAUTERY. By DR. G. APOSTOLI. (*Concluded.*)—"All electrical treatment should, then, always have an obligatory physical introduction, under penalty of relapse into the dangers of the past." The various instruments are here rapidly reviewed.

"First, a good galvanometer.—I say '*first*' because this instrument predominates all the others in importance; many faults can infect the others without annulling the operation, while the absence of a good galvanometer in the hands of the physician subdues the treatment to the caprice of hazard. . . . It is an instrument for the electric current, which measures its chemical energy; serving first to recognize the passage of the current, to show its smaller variations of intensity. It fills, then above all, the office of a galvanoscope. But its functions are still more elevated, it gives equally well the exact measure of the electricity used; that is to say it plays here the role of a true balance or an accountant—it doses and it weighs out the electrical current." In the place of the old galvanometers graduated in degrees of a circle (which every manufacturer produces to suit himself) the author has constructed a galvanometer graduated in milliamperes. This is a modification of the instrument used by Gaiffe, the first constructed in France. The advantage of a definite unit, the ampere, over the old method of estimation by the number of couples employed is obvious, a new pair of elements being more active than a worn-out pair. The voltameter he also designates as much less practical. The following demonstrates the importance of the galvanometer: "The introduction of the galvanometer has produced a true therapeutic revolution in substituting mathematical precision for the vagueness of empiricism, in fixing

* From the French. "*Sur un nouveau traitement, de la Métrite Chronique et en particulier de L'Endométrite par la Galvano-caustique Chimique Intra-utérine.*" Par le Dr. G. Apostoli, Paris, France.

definitely the value of this medicament in such and such a given case, in rendering comparable all the observations of the same genera, in making possible the two most important factors : (1) The intensity of the current in milliamperes. (2) The duration of the application. As the new therapeutics which I propose can only be sovereign under conditions in which the high dose of current is used, with its trophic and chemical effects, all the interest of my communication resides in this formula."

Second, the battery.—A battery is necessary that has a size of elements sufficient to furnish, from 30 cells, a current of 150 to 250 milliamperes during a period varying from thirty minutes to an hour.

Third, the intra-uterine electrode.—"After the battery, the physician should have at his disposal the sound to carry the current to the cavity of the uterus. In principle all the metals could suffice for this, provided one employs the negative pole which does not attack them : but the positive pole corrodes all the metals except platinum, gold and aluminium ; this results in a double inconvenience : First, the metal loses its polished surface leaving a rough place which may wound the mucous membrane ; moreover, and this is very important, if the metal is also attacked by the current, the action of the latter is spent in pure waste on the electrode, to the detriment of the mucous membrane, which in the actual case ought to be the object of our attention. One would make an erroneous calculation if in using the positive pole of the electrode in copper, for example, or in steel, or iron, one concluded that the whole action (electric) is carried on the uterus ; it has only absorbed a part, and the other is spent in pure waste." The uterine electrode must then be of such a material, as platinum, which is not acted on by the current : it must be long enough for application to the whole length of the uterine cavity ; and it must be insulated in its vaginal portion by "glass, caoutchouc or celluloid" preferably the last material, because it joins to its insulating property, that of an aseptic.

Fourth, the cutaneous electrode.—This applied to the abdomen allows the passage of the current without pain, heat, or the formation of eschar. The author still uses wet clay, which he first introduced in 1882, in a lecture before the Academy of Medicine of Paris.*

* *Sur l'emploi nouveau de la terre glaise en therapeutique electrique.*

"In proposing this as a medical electrode, I have formulated the following propositions which I have justified in my memoir :

1. "It facilitates and allow us to make more efficacious and more complete certain applications of the chemical galvanic-caustic destined for the treatment I recommend in lesions of a chronic rebellious nature.

Fifth, the Rheophores or conducting cords.—These must be pliable and yet strong enough to prevent the danger of painful interruptions of the current by their being broken.

Having passed over the physical introduction, the author takes up the technique of the operation, to which one must conform, to meet with success.

A preliminary tepid antiseptic vaginal injection (corrosive sublimate, 1 to 1000 or 1 to 2000) is administered and the woman placed in the dorsal decubitus, the knees drawn up; the corset must be removed and the dress loosened to afford perfect freedom of the respiratory muscles.

The wet clay electrode is placed on the abdomen above the pubes, warning the woman that it is cold but the disagreeable sensation will pass off directly. The battery being in place and the galvanometer interposed, the rheophores are attached.

The proper introduction of the intra-uterine electrode is an important element in the success of the operation. Having been previously warmed and rendered aseptic, the electrode is introduced into the uterine cavity, care being taken that the vagina and vulva are protected by the insulator. The treatment ought not to be commenced until the passage of a sound into the uterus causes little or no pain.

The intensity of the current must be small at first, beginning at about 20 to 30 milliamperes, and increasing during the first operation to about 80 milliamperes. The patient is thus gradually accustomed to the effects and psychological resistance can be better overcome. In subsequent sèances the current may be increased and in time may reach 200 milliamperes.

The passage of the current must never be begun suddenly, but the current strength at each sitting should be gradually increased.

In a small proportion of cases the uterus will be found irritable. Such are hysterical subjects who bear the current badly, and to these it must be administered in small doses.

The duration of an operation should not exceed ten minutes, the average duration being between five and ten minutes. It is best to stop the treatment directly the patient complains of pain.

2 "It assures a greater constancy of current by lessening the causes of variations in the external resistance to the current.

3. "It renders easy, applications of long duration.

4. "It is destined to popularize the practice of electrotherapy by completing and improving the list of electrodes.

5. "It serves to limit and to localize, as far as possible, the principal action of the current in reducing to a minimum in certain circumstances, the troublesome influence of its diffusion and of its derivative action.

6. "It diminishes the pain of the application, of the chemical galvano-cautery, at the inactive or indifferent pole and averts all fear of eschar."

The number of applications to the uterus vary according to the chronicity of the ease.

In recent cases, two or three applications will in all probability suffice, whereas in the more chronic forms twenty to thirty applications will have to be made; and in the still more chronic cases where there is much induration and the circulation of the blood is slow, the treatment will have to extend over a considerable period.

The sittings may be weekly or tri-weekly according to necessity. Among the high-class patients who can rest in bed after the operation, two or three sittings will not be too often; while among the poorer classes who work and cannot rest completely, the treatment carried out once or twice a week will suffice.

The first operation should be commenced shortly after a menstrual period.

After the operation the patient must have complete rest for one or two hours. Any hæmorrhagic discharge that comes on shortly after the operation is best left alone, as the rest will stop it; but the sero-sanguinolent discharges coming on after the second day are to be treated by antiseptic vaginal injections.

The accidents to be avoided are.—First, an unknown pregnancy and abortion. Second, re-excitation of a pre-existing perimetritis or parametritis.

These can be avoided by making a careful vaginal and bimanual examination, and excluding pregnancy; by not employing the galvano-caustic too strongly or too frequently; by carefully and gently introducing the sound into the uterine cavity; by cautioning the patient against excessive exercise, and by forbidding sexual intercourse during treatment. Third, acute attacks of pain simulating peritonitis.

"In hysterical females with a pre-existing ovarian pain, fear of the operation, even if small doses, provokes a crisis of acute pain in the abdomen, which feigns, to the eye of one who has no great experience, an attack of true peritonitis; fortunately it amounts to nothing most frequently; the attack is sudden and violent but yields either spontaneously or to the influence of simple means, and it is here especially that the triumph of a method I have praised,* the uterine Faradization, or vaginal in case of need, with a current at the tension of small doses, long continued, causes cessation of all the acute pain."

Among the general considerations of the advantages occurring from the use of the galvano-caustic the author places the following most prominent.

* Sur un nouveau traitement électrique de la douleur ovarienne chez les hystériques. Congress de Rouen, 1883.

1. "It treats the mucous membrane of the uterus.
2. "It constitutes a good intra-uterine antiseptic.
3. "It establishes derivative issue from the uterus, which should aid energetically the resorption of the exudates.
4. "It permits the use of the inherent qualities of each pole, by application of the positive pole to hæmorrhagic or ulcerative forms and the negative pole to the other forms." [Concerning the indications for the use of the poles, on page 49 a summary is given.]

The positive pole, acid, decongestant, hæmostatic, is useful above all in the hæmorrhagic, congestive or ulcerative forms ; it combats and prevents the tendency to excessive vascularity and by this same process becomes the indirect remedy against a rebellious leucorrhœa.

"The negative pole, basic, diffuent, little or not at all hæmostatic, is on the contrary destined to excite languid or perverted circulation of the ancient atrophic forms or the induration of chronic metritis by a potent intra-uterine agency. It is the remedy *par-excellence*, for chronic indurated metritis which is complicated by amenorrhœa or dysmenorrhœa, and it is addressed with equal success to other inflammatory processes in which hæmorrhage does not predominate.

5. "It puts to profit every local (galvano-chemical) and general action (trophic) of the current.

6. "It allows the current to traverse the uterus safely in its entirety."

The great advantages of this mode of treatment over other surgical procedures (curettage—injections, pasty or liquid—cauterization, potential or igneous) are that,—1. The method is easy; 2, the amount and severity of the treatment is known to the operator, who can regulate it at will ; 3, the cauterization is gradual and never sudden; 4, this method unites a chemical with a caustic action, a sort of galvano-chemical curettage; 5, every part of the uterus is reached; 6, it is harmless if minute care be taken; 7, owing to its double action according to the pole used, the therapeutic results may be either that of a hæmostatic agent or adapted to the relief of congestion; 8, it is a more certain remedy than any of those already employed; 9, it is of value in uterine inflammatory conditions other than those of metritis; 10, the operation is little or not at all painful and does not generally require the use of chloroform.

In his conclusion Dr. Apostoli remarks that he hopes to present a future memoir giving the integral statistics of his therapeutics; the complete history of the principal maladies, and the durable and permanent definite results that follow his treatment.

ON WEAKNESS OF VITALITY.* BY PROF. WIDERHOFER, Vienna.
 • (*Allg. Med. Centr. Zeitung*, 51, '87.)—Weakness of vital power is a most interesting chapter for the physician, for by his labor he can rescue many a prematurely born infant from certain death. One cause that children are brought into the world hardly fit to live, may be found in mothers, who are themselves yet children when they become mothers; the fœtus may be ripe, but its development is below the norm. Infants born in the seventh or eighth month lack vitality, and the same is the case with twins or with three infants at one birth. Where the mother has to aid in the battle for sustenance, or where she passes through severe sickness or affliction and no abortus followed, we can only expect the birth of a child which lacks in development.

How is the appearance of such an unripe fruit? A normal child weighs about six pounds or 3000 grammes; and according to weight we consider an infant weighing less than 2000 grammes, as wanting in vitality; according to the length of the body a ripe infant measures about 50 ctm., a babe under 40 ctm. may be considered weak in vitality. Babes are born of 1500, 1000 and even of 500 grammes, and we might raise them for some years, as we do hot-house plants, but what do we find? The babe is a great deal smaller, shorter, the skin of a reddish or pinkish hue or a mixture of red and yellow; it has no panniculus adiposus. The head is remarkably round. On the body we especially notice the deep position of the umbilicus, very close to the symphysis; the riper the babe is the more the navel moves upwards; the whole body is covered with lanugo, the sexual organs are far from being developed; in male babes the testicles have not descended into the scrotum; in female babes the labia majora are not developed, so that the labia minora can be seen. At a necropsy of such a babe we would find after opening the skull that the brain oozes out, as it is a mere jelly. If we take the brain in our hands it will run off in all directions; it has no consistence, only the large ganglia, corpus striatum, pons, medulla, are a little more compact; a real division between cortical and medullary substance in the cerebral hemispheres cannot be made out, there are yet no gyri or sulci; the meninges are usually of a bloody color, the brain itself being very anæmic. In the heart the fœtal courses, ductus Botalli, foramen ovale, ductus venosus Arantii, are still open. The liver is remarkably large, very succulent, hyperæmic, of a more or less yellowish color. The gastric and intestinal mucous membrane hyperæmic; the kidneys lobulated and in them exquisite infarct of urates. The umbilical blood vessels are closed, no thrombi in the arteries and veins, and full of fluid contents. The whole skin

* Translated for this journal by S. Lilienthal, M. D., San Francisco, Cal.

is remarkably thin, with very little panniculus adiposus, and on the extremities we meet considerable œdema, in some cases exquisite sclerema. According as the fœtus is more or less developed, the differential points will be more or less prominent.

What influence has such a state on the vital functions? The regulation of heat will be greatly deficient, they have not a temperature of 37, but only of 35, and if the babe is not well taken care of, it may sink to 30 or even 25, and our first duty must be to guard the child against the loss of heat. This loss of heat allows various explanations: the vital functions of the child are of a low grade: it has a weak respiration, hence a poor circulation, a very thin skin and may thus lose heat easily; it has no panniculus adiposus, no poor conductor of heat, and loses therefore easily some degrees in its temperature. When such a babe falls sick with a febrile disease, as pneumonia, then inflammation may run its course without essential increase of temperature. Respiration and circulation are deficient with such babes; the liver is considerably swollen, the biliary ducts are compressed, and the children are thus more or less jaundiced, and the icterus continues for some time. This again acts badly on the children; if an adult has jaundice, he is more or less apathetic, tardy in his motion, weak, and in children the influence of the biliary acid must also be considered in relation to the blood corpuscles as well as for their general state. In such children we meet œdema, and if very low, an œdematous sclerema, so called to differentiate it from the sclerema adiposum as found, *e. g.* in cholera infantum. Nothing runs out when we cut into a sclerema adiposum, the serum is used up by the copious evacuations, but when we cut into an œdematous sclerema, a copious icteric serum is discharged. All functions in such a child are more or less inhibited, cardiac action irregular and weak, the babe does not cry well, it does not move much its hands and feet, it lies cuddled up with feet drawn up to abdomen, the upper extremities pressed against the thorax, its breathing superficial and in consequence thereof atelectasis. The pulse can hardly be felt on the radialis, the beat of the heart weak, irregular, intermittent. Secretion of urine and excretion diminished; as combustion is not sufficient, urates form in the kidneys which are not easily washed out, the children suffer from colicky pains and uræmic symptoms may set in. Many of such children succumb to septicæmic manifestations. The navel does not dry up from the third to the fifth day as in a normal child, for the conditions for drying up are not present: it putrifies and falls off about the tenth or twelfth day; as the cicatrix has not yet formed and the umbilical vessels are still open, an infection, a septicæmia may be expected. Such children succumb easily to umbilical diseases, omphalorrhagiæ, cutaneous hæmorrhages, sclerema, etc., to atal-

ectasis and even to slight catarrhs. No wonder that their mortality is so great.

Our first duty is to keep the baby warm. In infant asylums a kind of double D is used with an internal and external wall, through which warm water constantly circulates at 30° C, or pillows filled with hot sand or hot bricks may be used so that the babe rests steadily in the same warm temperature; other physicians envelope babes, with the exception of the head, entirely with cotton, and on the back a space is left for defecation. Once or twice a day such infants may be indulged in warm baths of $28-30^{\circ}$ R. We remarked on the superficial respiration of such children, and therefore they must not be allowed to rest too long in the same position; they must be made to cry by a little shaking, for crying causes deeper breathing, and such a baby ought to cry every half hour once. If such a child is kept too quiet, it will succumb to atelectasis and passive gymnastics are of the utmost importance to keep it alive. Where œdema exists massage is indicated. Such a child has apparently no desire for food and it must be fed, as nursing is impossible. Often we pour milk through the nostrils, a spoonful of breast-milk each time suffices. Their nervous system is not yet developed; reflexes, as sneezing, is not produced, but they swallow the milk. Gradually the quantity can be increased. As their gastric and intestinal glands still lack in development and pepsine is not yet formed, a little lactated pepsine or diastase may be added to the milk to aid digestion. Coryza is dangerous, as too often they succumb to it. If such a babe, in spite of the best care, does not gain in weight during the first two weeks, the prognosis becomes ominous. With such gain in weight, we will be often astonished at the reward of having carried the infant through this perilous time; but still we must not expect that such a delicate plant will ever equal the sturdy descendant of healthy and able parents.

HYDRORRHŒA GRAVIDARUM. By A. Mijnlief, Holland. *Allg. Med. Central Zeitung*, 40, 1887.—Hydrorrhœa gravidarum consists in a discharge of yellowish serous fluid from the genitals, either of a large quantity at once or guttatim. Sometimes pregnancy is interrupted by it. Prodromal symptoms are a painful tension of abdomen, paroxysmal pains simulating labor. The discharge of the fluid often surprises women either during sleep or after lifting some heavy weight, after jumping or after a fall or kick. The quantity differs; 50 to 1,000 grammes every time; sometimes even more. In some cases the flow is continuous. Some women only observe it when moving about; others only when lying down. Its odor reminds one of sperma, and by boiling we find albumin. As its causes are mentioned: rupture of

amnion (especially by American physicians), accumulation of fluid between the wall of the uterus and the foetal membranes, between decidua and chorion (Schroeder), between chorion and amnios, etc. *Quoad vitam*, the prognosis for the mother is favorable, for the child far less. Anything which produces congestion to the uterus may be blamed for it: neoplasmata, inhibited involution, pregnancies in rapid succession, catarrhs, cardiac difficulties, etc. Predisposing causes are anæmia, chlorosis, scrofulosis, syphilis, hydræmia, a form of endometritis. Very little can be done for it; everything must be omitted which would irritate the uterus: coitus, over exertion, alcohol, etc. Rest and good food may be ordered. In relation to differential diagnosis: (1) Discharge from the bladder; involuntary urination from or during pregnancy. Chemical analysis and odor of urine: (2) From the vulva by hypersecretion of the gland, vulvo-vaginalis, or by rupture of cystic-degenerated gland. The quantity of fluid is here small and could only be taken for a hydrorrhœa during the first months of pregnancy. (3) Leucorrhœa vaginalis, colpo-hyperplasia cystica: (4) From the collum uteri, which is doubtful. Excluding all these sources, as also fibroma or carcinoma colli, we may suppose that the fluid comes from the uterine cavity.

ON NEURITIS PUERPERALIS. By Prof. P. J. Moelines. *Münchener Med. Wochenschrift* 9, 1887.—There is a neuritis which especially affects young women during puerperium or after puerperal diseases: The end branches of the nervus medianus or nervus-ulnares, or of both nerves in their sensory and motory fibers become affected, sometimes in both hands, but more in the right hand. The affection either begins already during the puerperium, or a few weeks later, reaches rapidly its acme, or may be preceded by tearing pains. It may last for a longer or shorter time, but usually disappears after some time; in the worst cases some defect may remain. The preceding puerperal disease may have been light or grave. Only twice Moelines observed a different localization: once paralysis of several muscles of the shoulder; once a slight diffuse affection of the plexus brachialis. Several times paralyzes of the lower extremities were observed, but they had been preceded by severe pelvic cellulitis, and thus the nerves were injured. All palsies, by pressure of the forceps or of the gravid uterus on the sciatic nerves, have nothing in common with our neuritis. Myelitis was several times observed after puerperium, and such a myelitis puerperalis stands in the same relation to this slight neuritis puerperalis as encephalopathia saturnina to the common lead-paralysis.

BOOK REVIEWS.

A SYSTEM OF GYNÆCOLOGY. By American Authors. Edited by MATTHEW D. MANN, A. M., M. D. Volume I: illustrated with three colored plates and two hundred and one engravings on wood. Lea Brothers & Co., Philadelphia.

We congratulate Lea Brothers on presenting in a so finished manner the fruit of the tendency of the day, a system of gynæcology purely American. It is true that a foreign reference creeps in now and then, but in the main the body of the work is a complete refutation of the aspersions cast upon the work of Americans as being unclassical.

Volume I. is honored by contributions from Henry C. Coe, A. M., M. D., E. C. Dudley, A. B., M. D., Henry J. Garrigues, A. M., M. D., Egbert H. Grandin, A. B. M. D., A. Reeves Jackson, A. M., M. D., Edward W. Jenks, M. D., LL. D., Matthew D. Mann, A. M., M. D., Richard B. Maury, M. D., C. D. Palmer, M. D., T. A. Reamy, A. M., M. D., A. D. Rockwell, M. D., Alexander J. C. Skene, M. D., Ely Van De Warker, M. D., and W. Gill Wylie, M. D.

The names of many of these contributors are sufficient guarantees that anything with which they are associated shall be of the best character.

In the division containing "The Anatomy of the Female Pelvic Organs" the work of the writer is to be commended. He has endeavored to harmonize conflicting statements that have arisen from the controversies of our most eminent authorities. Of especial importance are the considerations of the pelvic peritoneum (with "practical deductions," of the pelvic connective tissues, of the pelvic floor, and of the perineal body.

We should have expected to see Alexander J. C. Skene assigned a treatise on the diseases of the urethra and bladder; he certainly appears to very small advantage in "General Therapeutics," a portion of the work in which we put very little confidence.

"Electricity in Gynæcology," by A. D. Rockwell, is a careful exposition of its present use as a therapeutic agent.

Attention should be given to "Subinvolution of the Vagina," page 667, a subject worthy of more interest than that which it usually attracts. The "Historical Sketch of American Gynæcology," by Edward W. Jenks, is a fitting introduction to volume one. A very appropriate tribute is paid to the genius of J. Marion Sims, the "Father of American Gynæcology." Dr. Jenks, however, raises a smile at his egotism in imagining himself so important a factor, in the "Rise and Progress of American Gynæcology," as set forth by an occasional paragraph on his own work.

In conclusion, though we find it impossible to note all the subjects treated in this, the first volume, the character of the work is such that we say without hesitation, we are proud to place it by the side of any foreign publication on our shelves.

DU TRAITEMENT ÉLECTRIQUE DES TUMORS FIBREUSES DE L'UTÉRUS. (D'après la méthode du DR. APOSTOLI). Par le DR. LUCIEN CARLET.

THE TREATMENT OF UTERINE FIBROMATA BY ELECTRICITY. (After the method of DR. APOSTOLI). By DR. LUCIEN CARLET.

Through the courtesy of our friend in Paris, Dr. Georges Apostoli, we are enabled to present a brief review of this memoir of Dr. Carlet. The book contains many points of interest. The history of the use of electricity in the treatment of uterine fibromata is most complete and certainly of value for future reference. Dr. Apostoli's method of treatment as given to *l'Académie de Médecine*, July 29, 1884, is here reproduced in full and to this is appended the report of 94 cases with complete notes on the history, the condition before treatment, the treatment and the results obtained.

In *résumé* the author presents the following results: "A total of ninety-four patients, who could undergo the discomforts of the treatment have been cared for at the clinic of Dr. Apostoli.

- "1. Fifty-nine treated by the galvano-caustic positive.
- "2. Twenty-one treated by the galvano-caustic negative.
- "3. Five treated by the galvano-punctures preceded or followed by galvano-caustic positive or negative.
- "4. Nine treated successively by galvano-caustic positive or negative.

"N. B.—If we sum up all the operations that have been performed, we find:

- "1. Six hundred and forty-nine galvano-caustic positive.
- "2. Two hundred and twenty-eight galvano-caustic negative.
- "3. Thirty-six galvano-punctures negative.

"Space fails us to relate all the observations of fibromata which Dr. Apostoli has communicated to us and which include all the patients who have been treated in his office; of whom it is sufficient to say that these patients number twenty-four, the greater number being still under treatment, and that the total of galvano-caustics which have been applied, either positive or negative, exceeds in all two hundred. These observations by their clinical results, for the most part controlled by the physicians who sent these patients to Dr. Apostoli, amply confirm the therapeutical effects which he has given us to study, and, by close observations on the patients of the clinic, we are furnished a new departure

from the argument which we have just been following, that which presents a total of one hundred and eighteen malades and over a thousand galvano-caustics." We believe that the deductions of Dr. Carlet are worthy of notice in full and therefore give them space.

The general conclusions, which result from the whole of this work, can be summed up in the following brief propositions, which are characteristic.

"1. The new method of the treatment of uterine fibromata by electricity, inaugurated by Dr. Apostoli consists essentially in the application to the uterus of a continued current from a battery at a constant state, without any interruption during the *séance*.

"2. The seat of the application is always intra-uterine and concerns all the mucous tract of the utero-cervical canal.

"3. The electrode, constructed of platinum, an unassailable metal and in the form of an ordinary sound, is introduced the whole depth of the uterine cavity; its length governed by this last, and the vaginal portion insulated by a casing of rubber.

"4. In case the cervix should be impenetrable and could not be entered, one ought to make an artificial opening by puncture followed by a galvano-caustic negative, which causes a destruction of the solid tissues about the electrode, creating thus an artificial canal.

"5. The active intra-uterine pole will be positive in all hæmorrhagic fibromata or in those which are accompanied by an obstinate leucorrhœa: it will be negative in all the opposite cases, and in particular where there is an intense dysmenorrhœa or in addition perimetritis arrived at its chronic period after disappearance of all the acute state. This latter pole appears to accelerate the uterine regression more rapidly than the preceding; it often provokes at the commencement of its application healthy hæmorrhage, which the positive pole is afterwards destined to check if it is too prolonged.

"6. The same patient may present successively indications for the two poles following the variable symptomatology which they offer.

"7. The intensity expended in the circuit should be the strongest possible, and should reach if necessary one hundred milliamperes, therapeutic action being the function of this severity. Cases of intolerance of high doses are rare and can be clinically placed under three heads: First, Acute hysteria; second, enteritis; third, acute perimetritis with fever.—The operator ought never to treat the patient roughly and should be wholly interested to reach the maximum only progressively, in one or two *séances*. The greatest intensities are principally needed with the uterine cavity very deep and in obstinate metrorrhagia.

"8. The duration of the application ought to be as long as the patient can stand ; five to eight minutes and sometimes ten will be in general sufficient to give a cauterization all its intensity and efficacy.

"9. The number of *séances* should be as variable as the disease itself ; from four to five could give lasting comfort ; from twenty to thirty would be necessary in the average case to assure a manifest uterine regression and give the patient a restoration that would approach a cure.

"10. The time of intervention matters little for the cure of fibromata not hæmorrhagic provided it is intermenstrual ; if it is hæmorrhagic the indications are to operate even in the midst of the flowing. The treatment ought to be interrupted as little as possible and to comprise one or two *séances* a week.

"11. It is important in the highest degree to make the operation as active as possible, by increasing the electric intensity, and in consequence the cauterizing power of the active or intra-uterine pole ; all the efforts of the physician ought to be directed to making the other pole indifferent or inactive, in suppressing at the place of its application all pain and cauterizing effects ; loam or wet clay, proposed first by Dr. Apostoli, in 1882, answers very well for this purpose, by enlarging the surface of this electrode and by diminishing to a minimum the resistance of the skin.

"12. All the technique of the operation is comprised in a good *hysterometre* or uterine sound ; the operation being in itself only a kind of therapeutic *hystrometrie* when all traumatic action ought to disappear, leaving only an electro-chemical action in the highest degree.

13. It is preferable to operate on patients at their homes ; otherwise it is important that they rest after each operation for one or several hours. They ought, moreover, to stop all conjugal relations during the treatment.

"14. All the objections that can be made against the treatment are more specious than well-founded ; one alone will merit subsequent control ; it is its influence on sterility.

"15. The very great number of observations (118) carefully taken to this day, prove manifestly in favor of the absolute innocuousness of the method.

"16. The intra-uterine galvano-caustic brings on rapid regression of the fibromata but not their total disappearance. It completely restores the woman, suppressing the metrorrhagia and assuring to the one operated on a well-being often very rapid and durable.

"17. The comparative study of all the electro-therapeutical methods applied to the treatment of fibromata proves that the

method of Dr. Apostoli is preferable to all which have been employed before him."

A HANDBOOK OF GENERAL AND OPERATIVE GYNÆCOLOGY. Volume I. By DR. A. HEGAR (University of Freiburg) and DR. R. KATTENBACH (University of Giessen). In two volumes. This is also Vol. VI. of "A CYCLOPÆDIA OF OBSTETRICS AND GYNÆCOLOGY," (12 volumes, complete set), issued monthly during 1887. New York: WILLIAM WOOD & Company.

Through the indefatigable efforts of the editor, Dr. Grandin, the "Cyclopædia" is rapidly approaching completion. In this volume every possible consideration of diagnosis is presented; positions of the body, examinations without instruments, instrumental explorations, are all exhaustively reviewed. Anamnesis deserves a somewhat more extended notice. It is true that under this heading, lines of thought have been indicated, such as the origination of vaso-motor disturbances, reflex psychical complaints and the relations of even the most severe symptoms of sexual disease to general conditions, but, in a work of this scope, thought in these directions should have broadened out and given more than mere indications.

To avoid narrowness in specialism requires increasing vigilance to combat this tendency, as it grows upon one with increasing special knowledge, and it has no more vigorous enemy than a diligent study of the anamnesis.

Chapter II., Gynæcological operations, contains full descriptions of the minor therapeutical technique and of the elementary operations; being in fact a complete gynæcological minor surgery.

This portion also contains some very interesting facts as to preparation for laparotomies. Lawson Tait's results in laparotomy receive a careful canvass and with Keith, he is designated a specialist "*par excellence*."

In Chapter III. we advise those having those having aspirations to abdominal surgery to give "anatomical relations" a careful study. The surgeon who operates for talipes without a positive knowledge of the muscles involved would receive little confidence from his confreres. How much less faith will they have in one who proposes to make such a *special* operation as a laparotomy, without great previous experience and an extensive knowledge of the pathological relations by which he may at any step be confronted! This portion of the work, devoted to operations on the ovaries, contains the most complete review of the literature and statistics in this special branch, yet published.

Vol. X. of this Cyclopædia has appeared before the other volumes for reasons already stated. Diseases of the Female Urethra and Bladder, by F. Winckel, M. D., the first part of this volume, is

a counterpart, in merit, of his small work on diseases of women. This monograph of Winckel's contains some literature later than that of Alexander Skene's work, filling in the gaps to the present time. We consider the eighty-two pages given to the description of injuries to the female bladder and urinary fistulæ as the most important feature of the work. Part II. of Vol. X., Diseases of the Vagina, is the work of A. Breisky, M. D.

This portion takes up at length, congenital malformations of the vagina, acquired atresias and stenoses, displacements of the vagina, ruptures of the vagina, hæmatoma of the vagina, inflammatory affections, neoplasms, and intestino-vaginal fistulæ.

The last chapter with its descriptions of fistulæ forms a suitable complement to Winckel's portion of the volume.

DISEASES OF WOMEN.—A Handbook for Physicians and Students.

By DR. F. WINCKEL, Professor of Gynæcology, and Director of the Royal University Clinic for Women in Munich. Authorized translation by J. H. WILLIAMSON, M. D., under the supervision and with an introduction by THEOPHILUS PARVIN, M.D., P. Blakiston, Son & Co., Philadelphia.

This work is divided into seven sections, and we particularly admire the clearness with which the "contents" displays what may be found in each subdivision. Section I. contains "Anomalies and Diseases of the External Sexual Organs;" Section II. "Anomalies and Diseases of the Vagina;" Section III. "Anomalies and Diseases of the Uterus;" Section IV. "Malformations and Diseases of the Fallopian Tubes;" Section V. "Anomalies and Diseases of the Ovaries;" Section VI. "Anomalies and Diseases of the Uterine Ligaments, Peritoneum, and Pelvic Connective Tissue;" Section VII. "Anomalies and Diseases of the Female Breasts;" thus all the ground is covered except diseases of the female urethra and bladder.

The author in endeavoring to present an acceptable "handbook" has given us a peculiarly readable work, but notwithstanding this he has not departed in any way from clearness. Not only has his own experience been largely drawn upon but copious notes on the work and methods of others are scattered through the book.

As a work adapted to the needs of the physician and student, not one other "handbook" contains within a sphere of 700 pages its equal in fullness of description or illustration.

DISEASES OF THE SEXUAL ORGANS, MALE AND FEMALE. Anatomy, Normal and Morbid; Pathology and Physical Diagnosis of the Diseases of those Organs. Arranged in Eighty Full-page

Illustrations and One Hundred and Sixty Pages Text. By J. A. JEANCON, M.D., Cincinnati : Progress Publishing Company, 1887.

Division four is of equally good character as the three parts already published, which we have had the pleasure of reviewing. While the work is complete as regards the descriptive portion, the special features are its lithographic plates. The opening plate contains the instruments and appliances used in gynecic diagnosis and operations ; these are continued through plates two and three. The remainder of the lithographic illustrations are representations of the various modes of gynæcological operation and of diseases of the male sexual organs. Among the subjects of value in this division are intra-uterine injections, tampons, amputation of the cervix uteri, hysterectomy, laparotomy, affections of the vulvo-vaginal glands and urethritis in the female. While not especially interested in the subject of diseases of the male sexual organs, it is impossible not to admire the beautifully correct colored plates of the pathological anatomy of these organs, with which the last portion of division four is illustrated.

BOOKS AND PAMPHLETS RECEIVED.

SYNTHÈSE ÉLECTRO THÉRAPIQUE. RAPPORT L'EXPOSITION D'ÉLECTRICITÉ, Par le DR. G. APOSTOLI. Extrait de *L'Union Médicale*. [SYNTHESIS OF ELECTRO-THERAPY. Report to the Exposition of Electricity. By DR. G. APOSTOLI. Reprint from *L'Union Médicale*.]

SUR UNE NOUVELLE APPLICATION DE L'ÉLECTRICITÉ APRES LES ACCOUCHEMENTS. PAR LE DR. GEORGES APOSTOLI. Extrait des *Annales de Gynecologie*. [ON A NEW APPLICATION OF ELECTRICITY AFTER PARTURITION. By DR. GEORGE APOSTOLI, Reprint from the *Annales de Gynecologie*.]

DE L'APPLICATION DE L'ÉLECTRICITÉ AUX ACCOUCHEMENTS. PAR LE DR. G. APOSTOLI. Extrait du *Journal Revue Médicale Française et étrangère*. [THE APPLICATION OF ELECTRICITY TO PARTURITION. By DR. G. APOSTOLI. Reprint from the *Revue Médicale Française et étrangère*.]

LITHÆMIA. By J. W. DOWLING, M.D., New York.

SIXTEENTH ANNUAL REPORT OF THE STATE HOMŒOPATHIC ASYLUM FOR THE INSANE, AT MIDDLETOWN, N. Y.

CLINICAL CASES.

The following cases from practice were presented to the Boston Gynæcological Club, by the various members for diagnosis and prescription, these being held in reserve by the author until each member had written his opinion—hence the incomplete character of the cases :

Annie, aged 20. Parents dead. Mother died of phthisis soon after birth of patient.

She has always been frail, but attended school and suffered no unusual sickness other than dysmenorrhœa which has been such as to cause vomiting freely during the first day, followed by tenderness, etc.

August 29th, 4 A. M., was called. She had retired at ten, after taking pears and melon, and felt some distress in the bowels in consequence ; was awakened at one A. M., by the glare of a burning building near by and went to the fire scantily clad, and stood in the rain with thin boots, dampening her feet and shivering with cold.

After returning to her bed she felt pains in abdomen, nausea, vomiting, which continued with increased severity until I arrived. When I found her with a cold damp surface, deathly pale face, weak, almost imperceptible pulse, constant nausea, retching having thrown up ingesta and now only watery substance, complained of cramp in bowel ; could not locate definitely, but was pained through entire abdomen, had bearing down as though menses would occur as it was time.

The following day found pulse weak, quick, 120, temperature 102.3°. Skin hot, dry, nausea and ineffectual retching continued, tongue coated, no menses, abdomen distended, tender to touch, lies on back with knees drawn up. Following day, continued much the same, but with slight menstrual discharge, dark red. Find on palpation the abdomen distended between the crest of ilium and umbilicus, the tenderness preventing sufficient manipulation to make out the cause of distension.

The succeeding days much the same as to signs of pain, which gradually lessened and for a month her symptoms subsided leaving more prominent the tumefaction in the abdomen by the lessening of the tympanitis. The tumor occupied the space between the crest of the ilium and the umbilicus. At first it yielded somewhat to pressure but gradually grew harder, more defined in outline and lessened in size.

The menstrual period developed with less pain, was more normal than usual. Since which time she has constantly improved.

All evidence of tumor has disappeared. She was married about two months after her recovery from this attack and has had no occasion to consult a physician since, which is about four months.

The diagnosis at time of attack was peritonitis, later diagnosed hematocele. Treatment, verat. alb. and viride, bell., merc. proto. and for the menstrual pain, gel. was magical in its effect.

Was called in haste to see Mrs. G., who had been ill for two weeks and under regular treatment until the attending physician pronounced the case a hopeless one, when I was called in. Patient about thirty-five years of age, small in stature, light hair, blue eyes, was very delicate in her whole organization, mother of four children all dead but one. Patient had been in feeble health for years but being naturally ambitious she had done a great deal of hard work by way of managing her family affairs.

I was summoned on the 28th of October last when I found her lying in bed as pale as death, with the expression, as though it had been stamped upon her face, of terrible suffering and of great fever. Pulse so small and quick that I could not count it, vomiting everything she took into her stomach, but thirst was most terrible. Bowels elevated and so full of gas that there was marked tympanitis from pubic bone to ensiform cartilage.

Every few minutes she would shriek out with pain, as she expressed it, through the heart and down the left arm.

When she would have these spells, her pulse would disappear and she would look as pale as death and become unconscious. Bowels so sensitive that the least touch would give her the greatest suffering. She constantly called for water and as constantly begged that we would not touch her bowels, seemed to have the most terrible fear that somebody would touch her stomach or bowels. Thought she would surely die every time the pain took her through the heart, shoulder and arm. Think she was one of the most pitiable and imploring patients I ever saw. Being on my way to visit a patient out of the city and in great haste I made a hasty prescription and told them I would call on my way back. She had not had her usual menstruation for three months. Called upon my return and learned that her urine scalded her badly when passing and that the thought of passing it sent a thrill of horror all through her system. Had had no stool for days and feared having one about as much as she feared death.

What is your diagnosis, treatment and prognosis?

My diagnosis of the cause was endocervicitis with metritis, pelvic cellulitis, peritonitis and nervous angina pectoris, with very marked hyperæsthesia of the whole nervous system. My first thought was to relieve her great physical suffering which I did by giving her an opiate at once. Then gave acon. and bell. [(?) Ed.] in solution every fifteen minutes until relieved, then half hour, until

my return which would be inside of two hours. Upon my return found patient much more comfortable, said the pain through the heart was much relieved and no matter how severe the other suffering she could endure that ; but she knew that two or three more attacks of that terrible pain in her heart would kill her. Continued acon. and bell. every half hour and left opiate if pain in heart should return during night. And ordered bowels packed in cold water and alcohol equal parts. On the following morning found patient had rested a little and was in as good condition as could be reasonably expected. Bowels not much swollen, could not bear the least pressure or touch without great pain. Had not vomited quite so much during the night, but could bear nothing but ice on the stomach. Fever less, in that I discovered acon. and gave bell. and bryonia with acon. to be taken between other medicines in case fever came up during the day. Pulse small but could be counted and was one hundred and thirty. Patient gradually improved until the bloating of the abdomen went down, pain in heart ceased, stomach would retain light nourishment, but still the trouble with the water and stool remained. When I could make pressure upon the bowels I discovered a hard round swelling just above the pubic bone as large or a little larger than my two fists, and notwithstanding the deposits within the cellular tissues, I almost persuaded myself that with all the other misfortunes that had fallen to the lot of my patient, pregnancy had come also, but this swelling gradually disappeared as did the cellulitis, but last to disappear were some hard spots, size of silver dollar, and some a little larger, in the peritoneum. We kept up the hot water douche from two to four quarts twice a day. Applied an ointment of terebene and extract of wool. This application kept the gases out of the bowels and afforded the patient great relief. For medicine, patient got bell., bryonia, merc. cor. and thuj. with perhaps once a day one tablet of sulph. morphine and atrophina $\frac{1}{100}$. Yesterday patient was up, dressed, and walking about very comfortable.

In August, 1885, Mrs. W. consulted me for what she called prolapsus uteri. Mrs. W. is sixty-five years of age, has been a hard-working woman through her married life, which has been about forty years ; has borne three children. Is small in stature, very thin in flesh, but possesses a very clear, bright intellect. Upon examination for the uterine procidentia I discovered a very much enlarged abdomen, irregular in its shape, and when I probed the uterus I found the sound readily entered eight inches.

She stated that she had been flooding gently for several months until she had in fact lost all her health and strength. I found the cervix and vaginal walls protruding beyond the vulva. With the patient on her back, replaced them and put in a Thomas antever-

sion pessary large enough to hold them in place. For one month patient suffered no more trouble with the flowing, but after about a month while coughing violently out flew the uterine support, and on came the hæmorrhage again. Then I introduced a hard rubber ring large enough to hold things in place. When this ring or any support was in that was capable of holding the descending portion of the uterus and the vaginal walls in place, patient could ride or walk with comfort; even the flowing would cease. But after about nine months her feet began to swell and become dropsical. Examination of urine failed to reveal Bright's disease of kidneys, but the dropsical condition increased until the fibre in abdominal cavity was fast disappearing in the ropy accumulation of serum in the abdominal cavity, until the pressure became so great we advised tapping as the only means of relief. The urine was very high colored and but a few ounces per day. She consented and we drew from abdominal cavity eleven and one-half quarts of bloody serum. It was about as dark as port-wine. After this operation she was put into bed and kept very quiet. She did not experience any unfavorable symptom, but rapidly regained her former strength—appetite good and sleep fair, bowels regular and urine quite free. But she slowly filled up again and was again tapped at the end of four weeks from first tapping. This time the serum was of a light straw-color and flowed very freely. For three days after this tapping patient seemed as comfortable as after her first tapping, when suddenly she was taken with a severe chill and grew very rapidly sick. Vomited everything she took—vomited much green bilious matter, and bowels were too loose. Fever very high, accompanied by great thirst. Pulse very weak and very rapid, and to all appearances she could not live but a few days at the longest. Her mouth and tongue and throat were covered with aphthæ. But after two weeks of this terrible sickness she began to improve, and made a very fine recovery so far as inflammatory condition was concerned. But after a few weeks, four, I think, she was in condition for another tapping. Passed the trocar but no fluid came, but I soon found out that instead of having serum to deal with we had pus. Applied the aspirator and drew off three quarts of thick yellow pus. From the first evacuation of pus, appetite improved and there was a general improvement in the general health. Fibroid remains about the same. After the first evacuation of pus, it became thinner and more of a greenish-yellow color. We have had to draw off the pus about every two weeks, until we have taken away eighteen quarts. Have taken about three quarts at every tapping until the last time, when we could get only one pint, but the same in color.

What we want to know is, where does this large amount of water come from, or where was it secreted? Where was the large

amount of pus secreted and where was it retained, and what would you advise for treatment that the patient might be cured?

Some three months ago while trying to extend the time between tappings it burst out through the place where she was last tapped, and discharged some two quarts of thin greenish-yellow pus, very offensive. After this bursting out it closed for about two days, when it burst out again, and the discharge in quantity, color and odor was about as before. After this discharge the patient called my attention to what she called a core that she could not get out. I took hold of it with a small pair of forceps and drew out a white substance that resembled the core of a boil, as large as my thumb and twelve inches in length. Since then the discharge has been much less, only a few spoonfuls every other day or so, and odorless, but rather thick and yellow. My diagnosis of this case is interstitial fibroid of uterus, with cyst of the uracus first, and second, ulceration and breaking down of the sac lining which kept up the secretion of the large amount of pus that has been secreted, as well as furnished the core I drew out. Prognosis is unfavorable because so far as the treatment of such cases has been favorable it has been by putting in a drainage tube from the sac in the uracus down through the vagina, thus keeping up constant drainage until the sac hardens; but in this case the solid fibrous condition existing between the secreting sac and the walls of the vagina render such drainage impracticable, unless some of our rising gynecological surgeons possess knowledge, skill and courage sufficient to warrant them to drain through the fibroid.

This patient is now so comfortable that after months in bed, by wearing a Star pessary and keeping the bowels packed in absorbent cotton, she is up and about the house and able to do a little light work.

Mrs. P., age 35, married, has had two children, the youngest four years of age. Had a miscarriage at the fourth month one year ago. Menstruation commenced at the age of fifteen, always regular but painful. The pain commences about one day before menstruation and continues from two to three days. Was urgently called to visit the patient, and found her in the following condition, to wit: Great abdominal pain in the right iliac region, pulse full and bounding, 120 per minute, temperature in the axilla 102.2, respiration, 36 per minute. The patient lies on her back with the thighs flexed. In the right iliac fossa, there is recognized by palpation a tumor which seems to be deep-seated, immovable, and tender upon pressure. This swelling or tumor is recognizable upon vaginal and rectal examinations.

The patient suffers from nausea, vomiting, and obstinate constipation. This tumor by palpation is situated above and within a short distance of Poupart's ligament, and its external margin is

advanced to within an inch of anterior, superior spinous process of the ilium. It does not extend beyond the median line.

Diagnosis.—Perityphlitis.

Differential Diagnosis.—Typhlitis. Impacted fæces. Cancer. Renal Calculus. Circumscribed Peritonitis. Right Oöphoritis.

Treatment.—Absolute rest in bed. Hot fomentations. Local application of tincture of belladonna to the tumor. As soon as suppuration commences (providing resolution does not occur, which did in this case) a free incision should be made and evacuate the pus. Internal remedies, aconite, belladonna, veratrum viride, mercurius vivus, and hepar sulphur.

Miss H—, about 30 years old, teacher by occupation, not physically strong, nervo-sanguine temperament, has never had any severe illness. Menstruation commenced about 13. Always been quite regular, the menses occurring once in three weeks, and quite profuse. Alimentation good, defecation normal.

About two years since she began to suffer from paroxysms of pelvic and abdominal neuralgia, occurring at somewhat regular intervals of three or four weeks. They sometimes preceded the catamenia a week or ten days. At other times, at the commencement of or during the flow. They had gradually increased in severity, and are often attended with dyspeptic symptoms, such as nausea, vomiting, headache, *etc.* The patient is not usually very nervous, irritable or hysterical. Physical examination reveals no important pathological condition other than a light degree of pro-cidentia uteri.

Diagnosis.—Neuralgic dysmenorrhœa.

Treatment.—Ignat., lilium tig., cannabis ind. and bell. Rest and relaxation of nervous system.

Miss S., age about 30, light complexion, very fleshy, yet extremely nervous. For several years has had urinary troubles with inability to hold the urine when upon her feet. She has also had at times some pelvic inflammation and has been under treatment much of the time without much improvement. She has at present no pain or soreness except the irritation to skin and mucous membrane of vulva caused by constant escape of urine which she is powerless to control when on her feet. There is, however, *no* leakage when lying down. She has no pain in urinating and very little desire to evacuate the bladder after going six or eight hours without doing so. The urine was found to be very acid and heavily loaded with urates, which rendered it thick and muddy in appearance when cold, though entirely clear when heated. The introduction of a small catheter caused quite severe pain just at the neck of the bladder and the lining membrane of the viscus itself was very sensitive to touch.

The capacity of the bladder which should be normally twelve

or fourteen oz. was found to be only five or six oz., and this caused distressing distention.

Diagnosis.—Contraction, or concentric hypertrophy of the bladder.

Treatment.—Dilatation of the bladder by hydraulic pressure, *i. e.*, filling (by means of a common bulb syringe) with warm water as full as can be borne, and increasing the quantity a little each time.

Gelsanium is my first choice as a remedy for the enuresis, as I believe it due to a loss of power in the sphincter visicæ, and that it is of nervous origin.

Mrs. L., age 30, light complexion, nervous temperament. A lady of refinement and good social position. Married, and mother of several children. For nearly two years has had more or less soreness and pain in right inguinal region, worse at the menstrual periods and increasing in severity of pain from month to month. The pain is aggravated by pressure or by flexing the thigh upon the body, or stepping up as in going up stairs, or bending forward to button a boot. With this there has also been at two or three different times for a week or more at a time a burning and soreness of the vagina with profuse leucorrhœa, and frequent urging to urinate, which causes smarting and burning. This latter trouble has now been present several days.

Bi-manual examination discovered no evidence of any abnormal condition or position of the uterus, but to the right was felt an oblong body which was not firmly fixed, nor directly connected with the uterus, in size and form about like a small hen's egg. This was sensitive to pressure, but enough was borne to determine that it was not hard or fibrous but rather soft and elastic. Ocular examination discovered, first, a suppurating vulvo-vaginal gland; second, a red and inflamed mucous membrane throughout the vagina and covering the cervix uteri—from this, and also oozing from the os uteri was seen a free muco-purulent discharge. The endometrium was extremely sensitive to contact, especially toward the right cornua.

Diagnosis.—Chronic pyo-salpinx, and acute vaginitis and endometritis.

Treatment.—After thoroughly cleaning the mucous surface with H₂O, a glycerole of Hydrastis—on a wool tampon—was applied and Merc. prot. given internally. These to be followed after relief of the acute difficulty by Bell. glyceroles and perhaps Silica internally.

The patient was told that the "lump in her side" *might* require removal by surgical operation, but not until medicinal and topical means had failed to remove it.

SOCIETY PROCEEDINGS.

MASSACHUSETTS SURGICAL AND GYNÆCOLOGICAL SOCIETY.—The semi-annual meeting was held at the Parker House, Boston, June 15. Eight new members were added to the list and three names were dropped for non-payment of dues.

The following papers were read and discussed, *viz.*: Empyæma—Treatment by Paracentesis, by H. C. Clapp, M.D. Dysmenorrhœa, by David Foss, M.D. Hystero-Epilepsy, by H. F. Batchelder, M.D. Fracture of the Inferior Maxillary, by F. A. Gardner, M.D. An interesting case by W. H. Lougee, M.D. A New Operation for Lacerated Cervix, by H. M. Jernigan, M.D. Urethritis, by Geo. F. Forbes, M.D. Spontaneous Expulsion of a Uterine Fibroid, by C. M. Fuller, M.D.

Discussion of these subjects was participated in by many members and that upon such papers as are herewith submitted was to this effect :

Dysmenorrhœa.—Dr. W. H. Lougee.—Dysmenorrhœa is often difficult to treat successfully. A large proportion of cases are of neurotic character and must be treated as neuroses. Has seen very little benefit from dilatation. Believes little in the theory of *obstructive* dysmenorrhœa.

Dr. A. J. French thought the cause of painful menstruation was frequently in the ovaries, and described a case in which the left ovary was the seat of pain and was enlarged. This not having been much relieved by medicinal treatment he had advised removal of diseased organ.

Dr. L. A. Phillips : Considers dysmenorrhœa as only a symptom which may result from so many and such various causes, that each case must be carefully diagnosed and treated according to the individual conditions. While many cases are due entirely to derangements of the nervous system and may be treated as reflex disturbances, there are many more which are due to abnormal or pathological conditions in the uterine organs themselves, and while there may not be many really *obstructive* cases, there are some in which there is need of removing an obstruction as in one of Dr. Foss's cases where a small polypus in the cervical canal was the whole cause of trouble. Dilatation I believe rarely helps this pain except when acute antelexion is found, then it is certainly beneficial. As Dr. Foss has maintained—to treat such cases for any length of time without ascertaining the cause of the pain, is folly and cannot be considered as other than bad practice.

In the first case reported by Dr. Foss, I must differ with him in regard to treatment. That the granulations should be removed I agree, but I would not use caustic of any sort because of the con-

traction of the cauterized tissues which is apt to follow. But with a curette carefully used, these granulations could be scraped away and leave no bad after-effects.

Dr. Foss : Caustic causes no pain, and in experience no contraction.

Dr. H. K. Bennett : Thought obstructive dysmenorrhœa, while not *very* frequent was no uncommon form of the difficulty, and that dilatation was the best means of curing it. In many cases congestion of the tissues causes obstruction so that cramp-like pain, almost spasm, result. Hayden's Viburum Comp. a very reliable remedy in this class of cases. He endorsed what Dr. Phillips had said regarding caustics and the use of the curette for granular endometritis, and was in the habit of applying Iodine or Iodized Phenol after curetting.

Dr. J. K. Warren : The first and most important object in treating dysmenorrhœa is to find the *cause*. Had treated cases of the obstructive form and cited three cases. Two of girls in whom acute retroflexion caused a firm closure of the cervical canal; the third, contraction caused by previous application of caustic. For granulations he would use the curette, but never caustic as he had seen too many bad effects follow its use. The curette is not easy to use properly, but in skillful hands is often a means of curing such cases.

In the neurotic form of dysmenorrhœa, he considered electricity the best means of cure, and by its aid generally had success with neurotic cases.

Dr. O. S. Sanders : Agreed with Dr. Warren that we must look for the *cause*, and thought we should many times find it much further back than is generally supposed. Hereditary taints—improper diet—over excitement—nervous strain. Remedy these and the dysmenorrhœa will disappear. Emotional and nervous disturbance should be *avoided*. Prevention better than remedies.

Examination of the genital organs should never be made in these cases except as a last resort, especially in unmarried women, but the remedy for each individual case sought diligently as well as the cause.

Dr. J. H. Sherman : Do not let a patient suffer for want of an examination, but send her to a lady physician. If there seems to be any necessity to learn the physical condition, I think the ladies in the profession should do it.

Dr. D. B. Whittier : Regulating the diet, habits, exercise and emotions as suggested by Dr. Sanders cannot be done : it is impracticable. And regarding examinations of patients : if after the use of medicines it appears necessary to make an examination in order to ascertain the cause of trouble, I do it. Endocervicitis is almost as frequent in the unmarried as the married. Shall this

be allowed to continue indefinitely or be cured by local treatment? For my part, in such cases I will make necessary examination and applications, or dismiss the case if this be refused.

Dr. Burnett : Thorough examination of subjective symptoms, with treatment as indicated by them, should be the rule for the first few visits ; then if relief is not afforded, physical examination should be made, and such treatment as seems necessary applied, whether the patient be married or single.

Dr. Phillips : I am glad this discussion has taken so broad a scope. The suggestions of Dr. Sanders regarding the primary and antecedent causes are important and should be well considered. There is much that may be done to prevent the *causes* and thus avoid this troublesome difficulty. The position taken by Dr. Sherman I must take exception to. As *physicians* we should recognize no *sex*. If examination be necessary we should make it, and whether it be of the throat or the uterus makes no difference whatever. As to the feelings of the patients, my experience is that a large majority of them prefer to be treated by men rather than women ; and I very rarely meet any serious objection to a necessary examination except from some servant-girl or ignorant woman who is sent to me for treatment, and fortunately I see very few of these.

Dr. Kate G. Mudge : There are many women who suffer from uterine difficulties who will not come to physicians for treatment because they will not submit to examination. But with us they are coming more and more to the women in the profession, and I think it is only the ignorant class who object to women physicians. As regards the use of caustics, I would never use them, having observed many bad results in cases thus treated.

Dr. George H. Payne : Cases of dysmenorrhœa can be divided into two classes : obstruction and neurotic. There are many of the obstructive form, from closure of the Fallopian tubes, from tumors in the uterus, granular degeneration, acute flexions and even versions, anything which prevents the free escape of the menstrual fluid is properly of this class. Neurotic cases are often found associated with mental troubles ; remove these, and the dysmenorrhœa disappears. Caustic has much the same effect upon the cervical canal as in the urethra, and often causes stricture in both, and should not therefore be used.

The new operation for lacerated cervix was discussed but little, both because interfered with by supper, and because it had not been seen by any present except the president, Dr. Payne. Drs. Southwick, Warren and Phillips could see no great advantage over the use of cat-gut sutures, and it was thought the removal of the pins might be liable to be attended by unfavorable results,

from entanglement of strings, traction applied at right angles with the pins, etc.

Dr. Payne said, however, that the pins were easily removed, even having sometimes dropped out into the vagina themselves. The advantage is in repairing both cervix and perinæum at one sitting, without having wire sutures to remove from the cervix. Cat-gut not considered safe, as it is liable to be absorbed before union is complete. In both cases thus treated the results were entirely satisfactory.

Urethritis.—Dr. A. J. French : Have you looked carefully for caruncles ? I have known cases having very similar symptoms, in which these little sensitive growths were the cause of the whole trouble. I remember one in particular which I treated first with carbolic acid. This gave relief, but they returned again within six months, when they were thoroughly extirpated with the knife, and that was the end of her trouble from that source, a permanent cure being the result.

Dr. J. H. Sherman : I have cured these caruncles by applying nitrate of silver.

Dr. H. K. Bennett : I want to inquire if spinal irritation is not present in Dr. Forbes's patients. I suspect the urethral trouble is an effect, not the cause. We often have such symptoms which are dependent entirely upon spinal irritation, and no disease at all in the urethra or bladder. In other cases pelvic inflammation may be followed by spinal irritation, and then relief of the local or pelvic condition will cure the spinal trouble.

Dr. Phillips : If I understand correctly, Dr. Forbes found no evidence of inflammation in the reported cases, hence it seems to me they can hardly be called *urethritis*. In the first two cases, I should suspect a fissure at the vesical outlet, and after the years of treatment by medicines and medicinal applications, I should consider surgical methods. Complete and prolonged rest and relief from irritation have been found to be the only means of curing some such cases, and this is accomplished by making an artificial opening at the base of the bladder, through which the urine escapes. After six months or so this may be closed like any vesico-vaginal fistula, and the urethral irritability will have disappeared. In the third case I should judge there was probably a lesion of the cervix-uteri, which, though relieved by the described treatment, returns again and again, as we know it is very apt to do, and this inflammation extends to or involves the bladder. I think if the cervix were made whole the vesical and urethral difficulties would be cured thereby.

Dr. George H. Payne : I should think there was either a fissure, a caruncle, or granular inflammation. I have obtained excellent results from the application of chromic acid to this class of cases.

Dr. W. H. Lougee : I think spinal irritation, or neurasthenia, is much more likely to be the cause of trouble than fissure. You cannot prove the existence of a fissure, and I should hesitate to adopt so serious an alternative as has been suggested. With spinal troubles there is often associated strangury and vesical irritation. Opiates or bromide of potash will relieve all desire to urinate. When caruncles are present they should be removed with the knife. When catarrh of the bladder is severe, strong astringent injections can be used and well borne—even a strong solution of nitrate of silver, which will stimulate healthy action. In neuroses of the neck of the bladder we must remember that the least amount of urine causes pain as well as with fissure.

Dr. J. K. Warren : The first thing to be done in such cases is to *locate* the trouble. A polypus just within the bladder was in one case the cause of similar symptoms. Dilatation and removal of the growth cured. Diagnosis is not always easy. In neuroses, however, there will be no hæmorrhage, while from fissure, polypus, or granulations, blood will appear at times in the urine. When these latter conditions are the cause of trouble, dilatation should be made. If there is any cystitis, use injections of the indicated remedy, and in many cases sulphate of lime and chlorate of potash combined will prove very effective.

Dr. Payne : Our diagnostic point is this : In neurotic cases urine causes pain immediately when it comes into the bladder ; in fissure when urine starts in voiding. In both, but more in the latter, the pain continues for some time after urine is voided.

THE BRITISH GYNÆCOLOGICAL SOCIETY.—REMARKS ON VAGINAL HYSTERECTOMY. DR. F. A. PURCELL. Blundell, in the year 1828, was the first in this country to propose, and carry out successfully total extirpation of the diseased uterus by the vagina ; his patient lived one year ; the subject has been a moot point amongst gynæcologists ever since. Dr. West propounded, "The unanimous voice of the profession has pronounced it to be overbold, and has rejected it from among the legitimate operations of surgery," and Mr. Knowsley Thornton more recently says, "The immediate results must be totally different from those at present obtained, and the after results also, before the operation could be admitted to a place among the legitimate operations of surgery." Dr. A. Reeves Jackson, of Chicago, in a paper read before the American Gynæcological Society held in Philadelphia, endeavored to show that complete removal of the cancerous uterus should be discarded from practice, because it is a highly dangerous procedure, and holds forth no reasonable hope for permanent relief.

To the German surgeons * belongs whatever credit is due to its modern revival. Their results were known to be much ahead of those obtained in this country, where they had been bad ; their mortality may be put down as from 28 to 32 per cent.

Dr. Schröder, of Berlin, (whose death we have to deplore), up to 1884 lost eight out of twenty-seven patients in whom he performed vaginal hysterectomy, and admits that in his practice it is not yet to be called satisfactory, especially as far as the question of recurrence is concerned.

Professor Olshausen up to 1883 performed, or attempted to perform, vaginal hysterectomy twenty-eight times ; in twenty-five the operation was completed ; seven of his patients died—a mortality of 28 per cent.—two on the day of operation ; three of septicæmia on the second and third days ; one of carbolic poisoning on the second day ; one of iodoform poisoning on the sixth day ; one suddenly of embolism of the pulmonary artery on the twenty-sixth day. Of the seventeen remaining cases, in two no return took place for one year : in two, two years had elapsed without a return ; in four or five a recurrence had taken place. In one case he had removed the uterus in a pregnant woman ; she lived eighteen months.

Martin, in a letter dated April 12, 1884, gave an account of sixty cases in his practice, of which thirteen died—a mortality of 21.7 per cent.

Haidlen collected in the year 1881, 52 cases, of which 19 died, being a mortality of 36.6 per cent. Czerny collected in the year 1882, 81 cases, of which 26 died, being a mortality of 32.1 per cent. Billroth, Brunner, Hahn, and others have helped to swell the list. Sänger, of Leipsic, collected 133 cases, with 30 deaths, a mortality of 28.5 per cent. William A. Duncan collected from all sources up to the date of his paper, read before the Obstetrical Society, January 14, 1885, 276 cases, with 79 deaths, a mortality of 28.6 per cent. Let us contrast this with abdominal hysterectomy.

Hegar and Kaltenbach collected 93 cases of abdominal hysterectomy—63 died, a mortality of 67.7 per cent. ; and William A. Duncan collected 137 cases of abdominal hysterectomy, of which 99 died—a mortality of 72 per cent.

Abdominal hysterectomy, or Freund's operation, is, therefore, a very fatal procedure.

Mr. Thornton, in his observations (*Brit. Med. Journ.* Oct. 13, 1883, p. 713) on his Class II. (intramural fibromyomata), says : "Operations for the removal of such growths by abdominal sec-

* Sänger of Leipsic, Schatz of Rostock, Demons of Bordeaux, Schröder of Berlin, *Archiv für Gynäkologia*, vol. xxi. 1883 ; the *Archives Générales de Médecine* for August, 1883, and *British Med. Jour.*, Sept. 15, 1883.

tion are serious and dangerous, the operation nearly always involves opening of the uterine cavity and we are at once exposed to the risks of septic conditions. The result is seen in an immensely increased mortality, a mortality still so great that we must pause here and carefully consider what are the conditions which justify us surgeons in performing these formidable hysterectomies and partial hysterectomies. There can be no doubt that, since it has been generally recognized that operations in which the uterine cavity is opened should be concluded by bringing all the gut surfaces outside the peritoneum, the mortality has sensibly diminished. Those operations involving the opening of the uterine cavity should not, in my opinion, be undertaken unless the life of the patient is actually in danger from hæmorrhage, rapid growth of tumor or interference with the function of the bowels or other vital organ. . . . I shall," he continues, "not again in any case attempt a partial hysterectomy, as I am convinced that it is both safer and easier to remove the whole organ and deal with the cervix instead of the uterine wall."

Sir Spencer Wells agreed generally in these opinions expressed by Mr. Thornton.

We are now seeing established in legitimate surgery the operation of extirpation of the uterus for uterine fibroids, no matter what Mr. Thornton's views on the subject are, and it is to be hoped that we may regard the vaginal extirpation of the cancerous uterus as an eminently rational one in an affection so surely fatal when left to itself as carcinoma, claiming for it no more nor less than what is to be expected from excision of the tongue, the rectum, the breast, the thyroid, or the testis.

We certainly may hope that this operation will follow the lead of the other gynæcological operations, showing a better prognosis as soon as the technical methods become more perfect.

Like ovariectomy, vaginal extirpation of the uterus is progressively improving in its death-rate; vaginal hysterectomy should therefore, be persevered in with the hope that it will eventually become a far more successful measure than it has proved to be up to the present date.

The question whether it is possible to operate radically is that which may well be asked; this may, indeed, be difficult to answer and it would be an illusion to suppose it possible to decide it with the utmost certainty: prognosis will be confirmed but not with absolute certainty, by the microscopic examination. "Time is the only element which can prove the completeness or incompleteness of the removal of the whole of the malignant structure."

It is a question whether it is advisable to undertake extirpation if there be superficial primary cancer of the vagina, for where extensive parts of the vagina is attacked, the deeper tissue will

always be found diseased, and the operation will, most probably, not be radical.

Cancer of the cervical mucous membrane and of the body of the uterus always necessitates total extirpation of the organ.

Of the final results of surgical operations our information is scanty and requires a more rigid following up of each case. Freedom from recurrence, on an average, may be placed at fourteen months, which if extended to two years, a cure may be taken credit for. The prognosis will, no doubt, improve by and by, especially if the operation is performed early and radically. Besides, even if the recurrence takes place, as Dr. John Williams now willingly acknowledges, the patient suffers little toward the end of her life compared with the dreadful sufferings produced by ulceration, for the disease generally does not recur on the cicatrix in the vaginal fornix. It spreads upwards on to the pelvic cellular tissue and saves the patient from the dreadful symptoms of cancer, from hæmorrhage and ulceration.

Sänger holds the views that partial operation on the cervix should be reserved for those cases of malignant papilloma in which the growth projects into the vagina; that supra-vaginal amputation of the body of the organ after laparotomy, or Freund's operation, should be limited to those cases in which the diseased organ can not be removed through the vagina, and that vaginal hysterectomy should be the rule in all other examples of carcinoma.

In papilloma the superficial area of the vaginal mucous membrane is first implicated, then the epithelial glandular cell; infiltration towards the rectum and bladder with extension of the papillomatous growth along the cervical mucous membrane towards the uterus and uterine cavity. Papilloma, or the so-called cauliflower excrescence, or cancrioid, is the form of disease the early removal of which results in complete cure, but when left to follow its own course the result is similar to carcinoma. The former begins on the surface, while the latter has already made extensive progress in the deeper tissues before it reaches the surface and ulcerates. By the time it has done so neighboring parts have been infected, and extirpation is of no avail.

Herein lies the vital importance and necessity of seeing and operating upon cases in their initial stages if women are to be relieved from misery and suffering.

The frequency of the disease commencing in either lips of the os and of the cervix makes the question of treatment one of ever persistent importance; the disease is manifestly localized, and not general, in many cases, and a hope of cure is, therefore, not to be absolutely denied.

Practice seems to have separated itself into two widely diverg-

ing lines : on the one hand to treat the disease by extirpation of the part or of the whole organ ; and, on the other hand, to remove the disease only in those cases in which a protuberant mass presents itself, namely, the partial operation on the cervix with the application of Paquelin's cautery or some escharotic.

This latter practice implies abandonment of some women whom a more hopeful view might have helped to cure, and very many of whom might have been relieved, not reckoning of course, the immediate risks of the operation, which, before being undertaken, must be explained fully to the patient and her friends as a safeguard for the operator.

DISCUSSION.

Dr. Bedford Fenwick said that at that late hour he would only ask one question concerning Dr. Purcell's most interesting paper. What was the cause of death in the first case? He need hardly point out how important it was, to know this with reference to the question as to the recurrence of malignant disease primarily and secondarily. Mr. Reeves had expressed some doubt as to the possibility of determining the presence of disease in the broad ligament or the pelvic glands. He quite agreed with Mr. Reeves that an examination merely *per vaginam* might not satisfactorily clear up the point. But he would recommend that in cases such as those under discussion, where it was absolutely necessary for the operator's success and the patient's ultimate welfare, that the operation should not be undertaken, if the disease had implicated the neighboring tissues, that their condition should be previously investigated by examination by the hand in the rectum. The method was very little used in England, but it was frequently used abroad, and with much advantage. He had used it himself, and could therefore appreciate both the difficulties and the usefulness of the procedure. It required great care, gentleness, and patience to introduce the hand through the anus, and a clumsy or impatient or careless operator might of course do great harm ; but done as a careful surgeon would do it, as a *dernier ressort* for accurate diagnosis, it had been frequently done, and with perfect safety, and it gave a complete knowledge of the condition not only of the broad ligaments and the uterine fundus, but of the pelvic glands and cellular tissue.

Dr. Grigg stated that when in Berlin in 1879, he heard the late Professor Schröder lay it down as an axiom that the local mischief alone was not an infallible guide to an operation for extirpation of the uterus ; that no operation should be undertaken without a thorough examination of the broad ligaments and lumbar glands under chloroform (the "tuft narcose.")

Dr. Spanton observed that, in discussing the question of hys-

terectomy, it would be well not to lose sight of the fact that certain cases may arise in which the pedicle might be ligatured with advantage rather than clamped: that each case should be dealt with on its merits and not according to absolute rule. He considered that Dr. Purcell had been singularly fortunate in his experience of hysterectomy for cancer, but the high rate of mortality recorded by others ought to make us cautious in undertaking such an operation for malignant disease, the actual extent of which is often most difficult to determine. It would be a valuable guide if an authoritative expression of opinion were given by this society as to how far this operation is justifiable or wise for cases in which the disease is limited to a mobile uterus.

Dr. Edis thought that, unless the diagnosis was made at a very early stage of the disease, before the adjacent tissues had become affected, the probability of an early recurrence of the disease was very great. It had been shown by a large series of operations that supra-vaginal amputation was far less dangerous to the patient than total extirpation of the whole uterus, and the results equally favorable as regards recurrence. Dr. Edis had tried nearly every method of operation. The great difficulty met with was that the diagnosis was not arrived at sufficiently early. If the least suspicion existed of any case being malignant in its nature, in place of waiting to see whether the disease extended, steps should at once be taken to confirm or negative the suspicion, and treatment adopted accordingly.

Dr. Heywood Smith pointed out the extreme difficulty of recognizing cancerous deposit in the broad ligaments before the operation was commenced. This condition rendered the operation hazardous, as the cancerous deposit may extend laterally to near the pelvic wall, and it would be almost impossible to restrain the hæmorrhage. In a case he had operated upon it conduced to a fatal result, as the ligature failed to constrict the broad ligament sufficiently to cut off the blood supply.

Dr. Mansell Moullin pointed out that, if it was really the case, as Dr. Purcell said, that when the disease recurred its tendency was to spread upwards on the cellular tissue of the pelvis and not downwards to the vagina, thus sparing the patient much of the terrible suffering inseparable from cancer of the cervix and vagina, great benefit was undoubtedly gained by the operation. The sufferings entailed by the disease were so dreadful, and its nature so utterly hopeless, that a proceeding which offered such considerable relief was worthy of every consideration. He thought however that the success which had attended Dr. Purcell's efforts had made him over sanguine. The third case in which the vagina was greatly implicated and a large part of which had been removed in the operation, was in his opinion far too

advanced for surgical interference, and he looked for a recurrence in the parts at no distant date. It would be a great advantage to collect in a tabular form the subsequent histories of all the successful cases to settle this point more definitely and to determine what actual benefit may be expected from the operation, granting that in skillful hands the primary danger may be reduced to something inconsiderable.

Dr. Purcell said: Mr. President and Gentlemen, I thank you for the kind way you have received my paper, and am pleased with the discussion it has given rise to. The operation of vaginal hysterectomy has advanced in estimation, for to-night it has had no adverse criticism, an advance since the last occasion on which I brought the subject before you. The discussion to-night has raised the following points—that of diagnosis and consequent prognosis, whether the disease has spread to neighboring parts and the means effected to discover same, and as to some technical points in the operation.

In reply to Mr. Reeves and Dr. Heywood Smith, the broad ligaments in each of the cases were normal, and no disease was found in them; and as to the treatment of hæmorrhage from the uterine vessels in the broad ligament, none gave trouble, as I practised after trying the ligature, the placing close up to it on the uterine side two pressure forceps, so as to clamp the vessels. Having divided and freed the broad ligament from side of uterus, it receded together with forceps upwards. If the parts are or should be rotten, these clamp forceps may remain on for thirty-six hours, until no danger of hæmorrhage is apprehended. I remove them the last thing.

In reply to Dr. Fenwick, whether I had examined parts by inserting the hands into the rectum, I did not, for my hand would certainly do harm as it is rather large. The principle is sound if feasible; and in reply to Dr. Grigg, I did not examine under profound anæsthesia, such as he recommends and is done by the Germans. Every aid should certainly be adopted to insure a proper diagnosis and knowledge of infection beyond. In reply to the speaker who asks how I avoid inclusion of ureters: This certainly is a most material and critical point. When I get my finger above and around the broad ligament, and having drawn it down into view, I make a most minute investigation and search in the structure, namely, the broad ligament, for what may be there. The presence or absence of the ureter is then decided on. Its presence could not escape observation. The structures are easily spread out on the finger. Satisfied of the ureter not being present, the ligature is tied.

Dr. Fenwick asks how my first case died. This I cannot reply to. She lived ten months and a-half after operation, but

my inquiries have not elicited whether she died of recurrence or not. It is more than probable she had recurrence, but if I save the patient even six months of misery I claim the operation as justifiable. I congratulate Dr. Edis on having a case, as I understand, of vaginal hysterectomy alive two years after operation.

The society then adjourned.

ABSTRACTS.

—POISONING BY PENNYROYAL.—Mr. Girling, in the *Brit. Med. Jour.*, June 4th, reports the case of a woman, aged 40, who took one ounce of the essence of pennyroyal for suppressed menstruation. About an hour after, Mr. Girling found her in a state of extreme collapse. "The face was pale, cold and bedewed with beaded sweat, and the hands and feet were cold and clammy. She lay apparently unconscious; could at first be roused by shaking and shouting to her, rapidly sinking, however, into a state of profound coma. The pupils were of normal size and responded to light. The action of the heart was exceedingly weak, irregular and fluttering; the pulse at the wrist being scarcely perceptible. The first sound of the heart was almost inaudible, while there was distinct reduplication of the pulmonary second sound. There was jactitation and feeble retching, with much salivation, but no vomiting and no purging. Temperature, 97 deg. F. Breath smelt like peppermint." An emetic followed by stimulants produced good results and the patient recovered.—*North Am. Jour. Hom.*

—INFANT MORTALITY.—Dr. Lemon T. Bean, in *The Amer. Jour.*—Over-feeding, as is well known, is a prolific source of summer complaints. When the stomach and small intestines are gorged, fermentation, instead of proper digestion and assimilation results; and when nature rebels against cramming, we may encounter a fatal fever or diarrhœa. Parents should be instructed, as they value the lives of their little ones, to guard against the use of unripe and unsound fruits and vegetables. They should be taught that they should be given plain but nutritious diet, in suitable quantities and at proper times and intervals; that they should have plenty of fresh air, and that their bodies should be bathed daily. Also, that strict attention should be paid to the matter of clothing—its changes, as required by the changing season—so that "colds" may be avoided as a result of changes of temperature, especially in the evening. Unceasing vigilance and the exercise of good common-sense in the care and treatment of children are necessary to get them safely through the summer months.

In winter, we deplore the necessity of imprisoning baby in a stuffy, artificially-heated house. When the warm months shall allow him to live out-of-doors, he will, we predict, eat and sleep better; shake off all maladies incident to the cold and rawness of the winter months. By the middle of June, we dread the sun, as we did frost; and comprehend why the pious jingle couples "chilling winds and poisonous breath" as equal foes to mortals' weal. As warm weather comes, changes in clothing—notably in flannels—should be made cautiously. A woolen garment, covering the chest and abdomen, should be worn next the skin, all summer long, at least until the child has completed its second year. The mother should look wisely and seasonably to baby's clothing. Day clothing must not be worn at night, nor *vice versa*. It need not be heavy or thick. Exchange that worn in winter for one of moderate weight; and as the heat increases, this for one still thinner. It must be of wool, and long enough to protect the vulnerable parts indicated, by day and night.

These are simple precautions, but indifference to lesser perils than those which they may avert has filled many a home with mourning, and fewer children would succumb to the "heated term" were they followed.

Aside from these dangers a great part of the ills of infantile life comes from starvation. In a majority of cases of sickly, puny babes, on investigation, it will be found they get little or nothing from the flaccid, milkless breasts at which they are found tugging. If the mother nurses her child in part, and feeds it also, it will then generally be kept on very low diet, from fear of surfeiting it. Good, undiluted cow's milk will cure them far quicker than any thing else. All things considered, I feel quite certain that it is as easy to raise children by hand, if an abundant supply of good cow's milk can be had, as it is by the breast. But the child, while quite young, should not be fed by the spoon, and the milk should always be made as warm as breast milk.

Every careful, thoughtful mother will accustom her infant to take cold water, or, in case of colic and restlessness, hot water, from the time of its birth, all through the nursing period. How? By the use of a nursing bottle, which should always be kept scrupulously clean. The child sucks instinctively, and the mother will find her babe an apt scholar at the bottle business—when put at it early. She will find, also, that this kind of education will be of great service "in times of need." Children often become thirsty. Water is the best fluid for quenching thirst, and a large quantity is required to carry on the functions of the system. A child will take it freely by the natural mode of sucking, and it should be thus supplied frequently and freely, unless it be when the stomach is engaged with a meal. Teach parents to feed their children

properly, and to allow them, from birth, more water. Teach them that when a child cries it don't always mean that it is hungry; that the little growing human is a thirsty creature, and that its cry means water as often as it does food.

Hot water is the best anodyne and nervine for children. The infant stomach may be irritated and made feverish by too frequent feeding. Acidity, flatulency and restlessness may be due to the same cause; all of which may be readily remedied by the use of hot water. When nature rebels, as indicated by vomiting, diarrhœa, colic, etc., give it to the child freely, as hot as can be sucked, if it is still nursing breast or bottle, otherwise, have it drink it. If not readily relieved, in addition apply a flannel cloth wrung out of hot mustard water to stomach and bowels.

—CUOMO: THE OPHTHALMOSCOPE AS A HELP IN THE DIAGNOSIS OF BRAIN DISEASES IN CHILDREN.—(*Jahrb. F. K.*) The author complains of the failure of systematic writers upon the diseases of children to advocate ophthalmoscopy in their text-books, and adduces facts to prove its value. In his experience its application is always possible. If the children to be examined are comatose, the pupils will be wildly dilated and fixed and one needs only a single assistant to fix the head in the desired position. If the children are conscious, the effect of an intense light (reflected?) will be to arrest their attention and fix it long enough with dilated pupils to enable one to make the necessary inspection. In tuberculous meningitis, in addition to tubercles in the choroid, which are not constant, one always finds evidences of neuro-retinitis, cloudy papillæ, contracted arteries, and concealment of the entire fundus. In simple meningitis one finds hyperæmia with redness of the retina and choroid just as in hyperæmia cerebri. In chronic hydrocephalus the evidences of limited space in the cranial cavity will be manifest in distinction from rachitic hypertrophy, in which the symptoms are negative. In anæmia of the brain the entire fundus is pale and the vessels small. An early diagnosis is often possible by the aid of the ophthalmoscope, where otherwise it is not.—*Archives of Pediatrics.*

—FATAL RESULT OF INTRA-UTERINE MEDICATION.—Dr. Engström relates the following case in a Swedish medical journal: A woman, aged thirty-seven, had suffered from persistent metrorrhagia. The uterus was retroflexed, but no signs of past or present inflammation could be discovered. It was replaced and scraped out with a Simon's sharp spoon, two small spoonfuls of hyperplastic tissue being removed. A solution of iodine in iodide of potassium at 113° F. was then injected, the relative proportions of iodine, iodide of potassium, and water being 1, 2, 30. No fever and scarcely any pain followed. In five days' time a second

injection was used, the temperature being 104° F., and the relative proportion of iodine, iodide of potassium, and water 1, 2, 10. No pain was experienced, and the patient walked up and down stairs. On the evening of the second day, however, a rigor came on, followed by pyrexia, abdominal tenderness, diarrhœa, and convulsions, death occurring two days later. At the necropsy there was found broncho-pneumonia, chronic œdema of the lungs, endocarditis, and purulent peritonitis. The substance of the uterus was soft, friable, and gray-colored, containing specks of blood and lymph. The peritoneum over the uterus was of a yellowish-red color and covered with puriform matter. The Fallopian tubes and their fimbriated extremities were not dilated or particularly reddened, and the mucous membrane presented no abnormality. The os uteri was too small to admit a fine probe. A large quantity of pus occupied the peritoneal cavity. Dr. Engström does not think any of the injection can have passed into the tubes, still less into the peritoneal cavity, and believes that the fatal peritonitis was due to an extension of the inflammation directly from the uterine wall to the peritoneum.—*Medical Record*.

—THE CAUSATIVE ELEMENT IN UTERINE FIBROMATA.—Again the ubiquitous microbe has come to play, in an entirely new rôle. He has been sought for in almost every nook and cranny of the human frame, and usually some one has been able to find him there, but this time he is met with as the happy occupant and *causa prima* of all uterine fibroids and ovarian cysts, according to a curious and unexpected communication sent to the Société de Biologie by Drs. V. Gallippe and L. Landouzy. They believe that they have discovered a parasite which by its irritant action upon the tissue-elements causes the growth of these tumors. The experiments of these gentlemen were not sufficiently guarded against every possible source of error, nor were they performed as crucial tests sufficiently upon normal tissues and other tumors in a way to force us to adopt their conclusions as incontrovertible.

—AMMONIUM CARBONICUM.—Prof. Farrington, in *Medical Advance*.—Ammonium Carb. is suitable to stout women, especially those who lead a sedentary life. The vital powers are sooner or later affected, leading to coma or blood changes, which permit of hæmorrhages of dark fluid blood.

Menses preceded by cholera-like symptoms; come too early; flow too short; also, after a long ride. Blood blackish, clotted and acid. Magnesia carb. has black blood but it has not the acidity and has late menses. Veratrum alb. is similar in cholera-like symptoms. Ammonium carb. has fatigue during menses, worse in thighs, with yawning, toothache, pain in small of back and chilliness.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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No. 6.

NOVEMBER, 1887.

VOL. IX.

PESSARIES AND THEIR APPLICATIONS.

BY PHILIP PORTER, M. D., DETROIT MICH.

(Continued from page 407.)

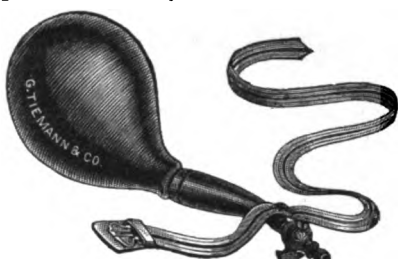
. *Vaginal Pessaries.*—'Tis here the inventive mind of the would-be gynæcologist has run rampant with all the well-known laws of mechanics, and as witness to his fertility we have had foisted upon us every possible combination of physical laws, in so far as they may be applied to uterine deviations.

With all the anatomical relations to observe, as well as the individuality of each case, how soon is gravity, fulcrum, axis, lever, in truth, all rules and laws of that science which treats of the action of forces on matter, thrown to the winds, and the surgeon's own personal views substituted to satisfy the patient that *he* knows all there is to understand

about her respective case, as he had "hundreds of similar cases to treat."

The question of material is briefly disposed of, the popular ones at present being hard rubber and the different kinds of flexible wire covered by soft rubber. A good substitute is made of several strands of fine wire laid together and arranged so that each end shall come in a different place, the objection, however, being that they are more

liable to break, being more susceptible to the action of the rubber and the secretions than the larger wire, and when one strand is broken the instrument is dangerous to use.

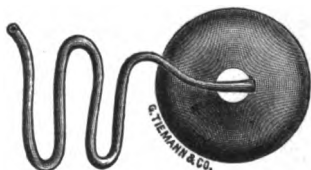


No. 18.—Braun's Colpeurynter.

The air-bag pessary, or Braun's improvement, the

colpeurynter (No. 18), is more adapted to large, flabby vaginæ; so are all that style or form of pessaries, such as rings, glass, wood, rubber, etc., which by their presence retain the displaced organ simply by their size and the distention.

The soft rubber, inflatable, ring pessary (No. 19), and Meyer's (solid) soft rubber ring pessary (No. 20), I regard



No. 19.—Soft Rubber Inflatable Ring Pessary.



No. 20.—Meyer's (Solid) Soft Rubber Ring Pessary.

as the most innocent, and yet the most delusive instrument we have. By its peculiar form of construction and the various kinds of metal of which it is composed, it apparently is capable of relieving almost all forms of displacement; but behind the correction of the malposition is the fact that it

simply adds to, or aggravates, in most cases, the former cause of the prolapsus, by putting upon the stretch all the supporting tissues of the uterus. By the pressure of this form of support, all the elasticity is destroyed, and, as one writer so aptly makes the comparison, the tissues become not unlike an old rubber hat string—the string left, but the rubber gone. So with the employment of the ring (No. 21),



No. 21.—Ring Pessary.



No. 22.—Bozeman's Vaginal Dilator and Pessary.

or bag pessary;* they destroy the very condition we are by our internal remedies trying to restore.

The objection to the other forms, where the long axis of the pessary is made to correspond with the vaginal canal—made of soft material—is the liability to change if any undue force is brought to bear upon the instrument by the patient using any extra amount of force in daily life. In cities, where there are instrument makers, the surgeon can soon meet and correct this fault; but the practitioner who is not so fortunate must make use of such material as will retain a permanent position, such as hard rubber, celluloid, copper or block tin; the latter are not adapted for long wear, as they soon become corroded and roughened by deposits of vaginal salts. Therefore we must go back to the first satisfactory material—hard rubber and celluloid. The latter, however, has not so far been found suitable to our use, and we are still compelled to use the hard rubber, which, in the hands of the skillful manipulator, who, as we

* The same is true of Bozeman's vaginal dilator and pessary (No. 22), the employment of which is only admissible in certain conditions, as vaginismus.

have before stated, has the natural—it might be cultivated—rare gift, of properly treating on scientific mechanical principles, uterine displacements, has proven a boon to sorely afflicted womankind, who cannot afford the expensive luxury of a colporrhaphy (elytrorrhaphy), or the more natural operation, colpo-perineoplasty.

Application of Pessaries.—The successful application of a pessary depends upon general indications; there may be a flexion, a version, or prolapsus, or the vaginal wall may be prolapsed, anteriorly or posteriorly. From lack of lateral support, the uterus, while well up in the pelvic cavity, may by its great amount of mobility, be permitted to shift about and produce painful pressure forward or on either side, and may require some form of simple support to keep it in its proper position.

When dwelling upon the indications for the adjustment of pessaries we wish it to be distinctly understood that every uterine displacement does not require artificial support. But when *mechanical* interference is *necessary*, the following rules should be regarded with some degree of caution. There are many conditions, too, such as counter indications, which we will not refer to, as it is our duty to consider cases that demand vaginal support, and we shall pass directly on to the indications for the selection, management and application.

The degree of knowledge of the practitioner will usually govern his success in adjusting a pessary. His first mistake is that the fault is sought for in the pessary, not in the manipulator. The second is in selecting too large a pessary, or one not bent and curved properly. The angles are too abrupt and the soft parts are crowded too much. Third, he does not watch the instrument carefully enough.

The first important rule should be, if there be any *pain*, examine the state of affairs *at once*. If the physician appreciates the mechanical principles underlying the action of all vaginal pessaries in their relation to uterine displace-

ments, his work is much more easily performed. If on the contrary he "goes it regardless," he will not only meet with disappointment but bring odium upon an instrument that, if properly employed, is really a benefactor to the sex. There are three mechanical ways by which pessaries act; first, by the *size* of the instrument; second, by *direct pres-*



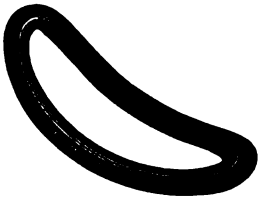
No. 23.—Hard Rubber
Bi-concave Disk.



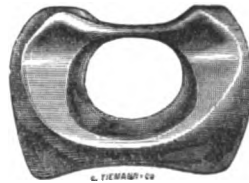
No. 24.—Globe Pessary.

sure or support; and third, by what is known as the lever action.

First.—Those pessaries which act only by their presence (size) must be regarded as affording only temporary relief by distending the vagina. In the aged, this treatment may suffice, but in the young or middle aged person this method simply destroys by persistent pressure the very activity (mechanical) which supports the uterus, and



No. 25.—Hewitt's Pessary.



No. 26.—Hoffman's Pessary.

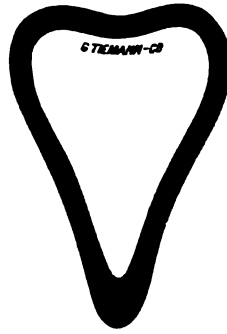
removes from all supporting parts that elasticity which Nature gave. Under this class we name the rings which expand by their centrifugal action, the air-bags, Zwanck's, all forms of disks (No. 23), or globes (No. 24), and the various soluble preparations, introduced under different

names, which are usually astringent in their physiological action, and while they last support by contracting the relaxed parts.

The second class includes those pessaries which act

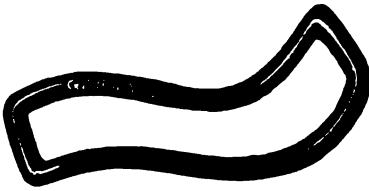


No. 27.—The Sleigh Pessary.



No. 28.—Buttle's Pessary.

through the direct support they give to displaced structures by raising or elevating the prolapsed organ, but not correcting the deviation. As examples of this class we have Hew-



No. 29.—Rees' Pessary. 1. Retroversion.

itt's pessary (No. 25), Hoffman's pessary (No. 26), the sleigh pessary (No. 27), Buttle's pessary (No. 28), Rees' pessary (anteversion and retroversion), (No. 29), Willhoff's pessary (No. 30),

and Hank's galvanic pessary (No. 31).



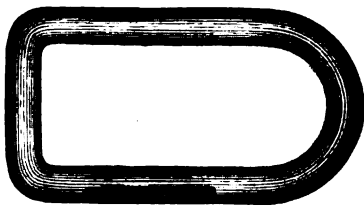
No. 29.—Rees' Pessary. 2. Anteversion.

The third class of pessaries are those known as the lever pessaries, and to-day are the recognized mechanical support for marked deviations, such as flexions, especially the backward form.

The popular instrument is the Hodge lever (closed), and the Albert Smith. We therefore have, we might say, but one action, and that is confined to

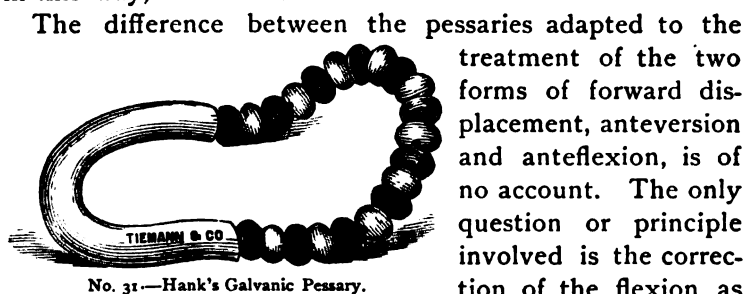
that space between the pubes in front and the uterus behind, employing such instruments as will bring the cervix forward and force the fundus upward and backward, in forward displacements, or *vice versa*, carrying the cervix backward and the fundus forward in backward displacements. This treat-

ment I believe the rational one in all forms of displacements forward or backward. The popular treatment introduced by Thomas and Graily Hewitt, of replacing an anteverted or anteflexed



No. 30.—Willhoff's Pessary.

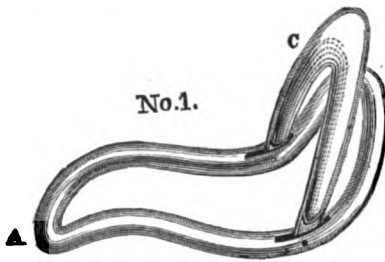
uterus, is, I believe, faulty in the extreme, and can be made applicable but to a few cases. The "buckle" pessary of Thomas (No. 32) for anteversion can be tolerated by few women. Their introduction is painful, and in the hands of one less expert than the originator, they are not liable to be permitted more than one trial. Any instrument which distends the posterior pouch of the vagina and thereby *draws* the cervix backward always counteracts the supporting effects of the pessary. Never select a pessary which by its peculiar shape or action will, in this way, force the cervix backward.



No. 31.—Hank's Galvanic Pessary.

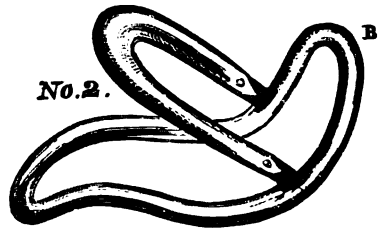
The difference between the pessaries adapted to the treatment of the two forms of forward displacement, anteversion and anteflexion, is of no account. The only question or principle involved is the correction of the flexion as well as raising the entire uterus to its proper height within the pelvis. There is one thing to remember in treating all forms of flexions. See that the anterior or posterior bar is high enough to avoid dropping into the notch, thus aggra-

vating the circulatory disturbance and producing more harm than good. In the various forms of anteversion, the



No. 32.—Thomas's Anteversion Pessary (Buckle)
Closed.

Thomas (No. 33), and Hewitt (No. 34), instruments have served me well, but understand, no vaginal support, however direct, or well it supports, will straighten an ante-flexion. Dr. Gehrung's (No. 35), will do more, perhaps, to correct an ante-flexion than any other form of pessary, as it lifts the fundus higher than any other instrument. All instruments within the vagina correct the forward flexions more by relieving the anteversion than in any other way. I therefore depend more upon this pessary (Gehrung's) for the treatment of forward displacements of the uterus than on any other. As seen, it is only a Hodge closed lever—bent upon itself. In other words a "double horse-shoe." The mechanism is simple and yet appeals to one's idea, in the application to a forward deviation of the uterus. The lower portion of the instrument rests upon the floor of the vagina and thus the two ends of the pessary are left to adjust themselves to that space back of the symphysis pubis and in front of the fundus uteri.



Properly selected and placed within the vagina, anteversion is impossible. Like all of the pessaries, after the Hodge principle, coition is admissible. Some practice is required to introduce the instrument without distress to the patient. We could devote the entire

No. 32.—Thomas's Anteversion Pessary (Buckle)
Open.

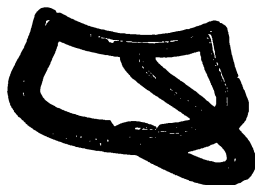
time allotted to us by considering only the mechanical treatment of the forward displacements, but we pass on to a review of the relief of backward deviations of the uterus.

The double lever pessary has the correct mechanical principle governing the treatment of the retro-displaced organ.

The short, stout, curved arm of the pessary, made with regard to the depth of the



No. 33.—Thomas's Anteversion Pessary, Closed.



No. 33.—Thomas's Anteversion Pessary, Open.

posterior vaginal couch, passes be-

hind the cervix; the long, easy, graceful curve of the other portion of the instrument finding a soft flexible yielding place, elastic in nature, along the anterior wall of the vaginal canal which finds its fulcrum at the deepest point of the curve of the pessary, on the posterior vaginal wall, especially in cases where the vaginal tissue retains its natural condition, at that point where Douglas's cul-de-sac is first formed in its anterior portion. Let us understand, however, that we have not a fixed fulcrum to deal with, but one that changes its point of action with every change of the body. The Hodge, closed lever, is a standard instrument. The open lever pessary is now seldom used owing to the danger associated with it. The modified Hodge, Albert Smith pessary,



No. 34 — Graily Hewitt's, with Closed Bars.

meets some of the objections raised against the Hodge. The Hodge is apt to turn over, in large relaxed vaginæ, where there is much deficiency of connective tissue, which is not the case with the Albert Smith pessary, if adjusted with regard to its indication. Of late there has been a disposition on the part of an English physician, Mansell Moullin, to ridicule, as well as demonstrate, the fallacy of the physical law observed in the mechanical retention of the dis-

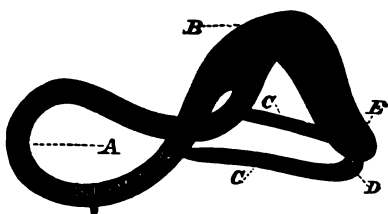
placed uterus, known as the lever principle, now recognized the world over in the construction of vaginal pessaries. Many



No. 35.—Gehrung's Pessary.

changes have been made in the Albert Smith instrument, but the general rule governing their action has been retained except in some cases to change the base of support, some placing it behind the symphysis pubis, others placing it nearer the posterior cul-de-sac. Dr. Gehrung has also constructed an instrument which to some extent is an improvement over the Albert Smith. It is so made as to prevent the pessary from slipping sidewise, which often

happens in the ordinary round curve. The supporter has a notch or central depression in the upper curve in which the uterus rests. The Thomas pessary with the large posterior bar is an excellent improvement in many ways, especially in assisting the retention of prolapsed ovaries. They are now manufactured hollow so that they are light, but they can not be changed in form as well as other pessaries.



No. 36.—Skene's Cystocele Pessary.



No. 37.—Bozeman's Soft-rubber Pessary.

The instrument we appreciate most highly is a modification of the Smith pessary, that is, the Studley of which we have already spoken at length. This idea of Studley's is the one which all the "shop-ready-made-self-adjusting supporters" like the McIntosh, Herrick, Shannon, etc., have

adopted, and the principle will surely hold good if all things are equal. These "self-adjusting" pessaries have a dangerous element; we say "dangerous," because every uterine deviation must have a support which is peculiar to that case. We are compelled from what we have seen to condemn all "ready-made" supporters, for in the hands of the ignorant they can do much injury—yes, irreparable damage.



No. 38.—Kinloch's Pessary for Cystocele.

The only suggestion we should offer in the selection of an Albert Smith pessary, is this, always carefully measure the vagina and adapt the curves of the instrument to the dimensions and shape of the canal. If this is done, your patient will not complain of the pessary when she goes to stool, or of the pressure on the rectum.

There are many well-known pessaries that we have not spoken of, but as they are only duplications of the mechanical principle we have mentioned, we shall not refer to them, only adding that every instrument constructed for the support of a displaced uterus has in each particular case an advantage peculiar to itself. Keeping in view, when adjusting a pessary, the few rules to which we have referred,

you will *use*, rather than *abuse*, properly adjusted, artificial support.



No. 39.—Skene's Improved Cystocele Pessary.

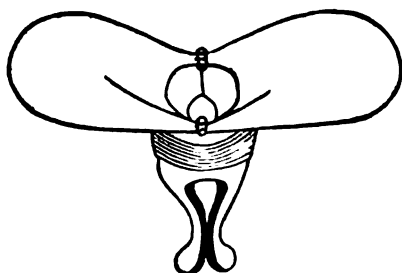
There is one thing more we would speak of, and that is in all cases of forward displacement, we must direct the patient to make an effort to

assist the vaginal support by manipulating the bowel upward as in cases of hernia. The patient should be instructed, when prepared for retiring, to assume a position on her back at the edge of the bed, placing her feet on an

ottoman near by, and to gently kneed the abdominal contents upward. The advantage of this treatment is sufficiently comprehensible to all without further reference.

In cases of the opposite displacement, backward, the knee-chest position, with the vagina inflated, should be employed.

No part of the vaginal canal is so tender and sensitive to manipulation as that portion between the cervix and the pubes. In consequence of a fixation, as compared with any



No. 40.—Nøggerath's Pessary.

other portion of it, of the anatomical structure of the fundus of the bladder with its attachments to the pubes, and of the tension in this region caused by the anteversion, and increased by the shortening of the utero-sacral ligaments, we have to deal

with a part that demands gentle and gradual approaches, or otherwise trouble in the way of actual pain, and even a solution of continuity is liable to follow. Whenever a woman complains of distress after the introduction of a pessary, we again urge an investigation.

There are special instruments which have been constructed for the relief of cystocele, rectocele and prolapsus uteri, that have been touched upon, and we will but briefly call your attention to Skene's cystocele pessary (No. 36), Boze-man's soft-rubber (No. 37), Kinloch's for prolapsus of the bladder (No. 38), Skene's improved cystocele pessary (No. 39), Nøggerath's pessary (No. 40), and the various styles of rings and rubber bags.

VAGINISMUS AS A FACTOR IN THE PRODUCTION OF LACERATED PERINÆUM.*

BY SIDNEY F. WILCOX, M. D., NEW YORK CITY.

That vaginismus may be a factor in the production of lacerated perinæum has not been especially noted by any author that I know of. Some authors have mentioned the fact that rigidity of the perinæum during labor may cause a laceration, but do not especially mention it in connection with pre-existing vaginismus.

Sims† mentions a case where extreme vaginismus still continued after child birth, and one miscarriage in spite of the perinæum having been lacerated down to the fibers of the sphincter muscle, but he does not speak of the vaginismus as being a cause of the laceration, but simply shows that the nervous spasm is not cured by tearing open the vulvular orifice.

Schroeder‡ cites a case seen by Benicke in which the lower portion of the vagina was so narrowed during labor by vaginismus that it was necessary to perform craniotomy, and that the vaginismus persisted after the birth to an astonishing degree.

My attention was drawn to the fact of perinæal lacerations as a result of vaginismus by a couple of cases which have come to my notice, and I relate them with the hope that they may clear up certain points in relation to the production of lacerated perinæum, and perhaps relieve the minds of some who cannot see why a certain case in their practice should have met with such an accident.

CASE I. I was called out of town to sew up a ruptured perinæum in the case of a lady who had been delivered that morning with the forceps. She was above the average height,

* Read before the New York Society for Medico-Scientific Investigation.

† Clinical Notes on Uterine Surgery, pp. 333-335.

‡ Lehrbuch der Geburtshülfe, p. 493.

well proportioned, and a primipara. Physically there seemed to be no reason why the child, though a large one, could not have been born without injury to the mother, and yet on examination I found the perinæum completely torn through into the rectum, and the rent extending up to the septum. The tissues were so discolored and swollen as to make a correct appreciation of the amount of damage difficult.

The following is the history of the case given by the physician in attendance, and supplemented by the husband afterward :

The lady had been married about two years. The husband informed me that after marriage all attempts at copulation had been attended with intense suffering on the part of the wife, and that it had been fully three months before he had been able to effect penetration. So much trouble was experienced that finally she went to a physician to see if there was not some mechanical obstruction, but other than that caused by the nervous spasm there was none.

After awhile, however, conception took place, and pregnancy proceeded without any more than the usual unpleasant symptoms. Either some mistake was made in the reckoning, or it was a case of prolonged gestation.

Labor began in the morning, with slight nagging pains which continued at intervals of half an hour during the whole day until about 7 p. m., when the first examination was made. When this was attempted the patient shrank away and complained that the parts were so very sensitive and the lightest touch of the vulva would cause great suffering. The pains kept on increasing in frequency and intensity up to 12 o'clock, when they were very severe, and continued so until the early morning without much, if any, progress. The head appeared to be lodged at the inferior strait. Digital examination, which was now excessively painful, and which would cause the patient to become almost rigid, revealed a normal first position of the head, with the os well dilated, but no progress being made. In the morning, finding his patient was

becoming exhausted with her ineffectual efforts, the doctor sent for another physician to come and apply the forceps. The patient was anæsthetized with chloroform, and although the limbs were relaxed, I do not think the perinæum could have been completely so, for it often happens that although a person seems to be completely under the influence of an anæsthetic, irritation of sensitive parts will bring on indications of sensation. This I have often noticed in operations about the rectal and vaginal outlets. This patient took the chloroform badly, and the most extreme caution had to be exercised in order to bring her through safely. Therefore I think that, although there was relaxation of the limbs, the anæsthetic was not pushed to the extreme, and rigidity of the perinæum remained, and as considerable force was used in the extraction the laceration ensued. The condition of things on my arrival was as before described, and I did not give much encouragement to hope for primary union. The parts were brought into close apposition with animal sutures in the rectum and vagina, and deep silver sutures through the bottom of the perinæum. The patient recovered well, but the greater portion of the wound failed to unite. The sphincter ani did unite, however, and although a small recto-vaginal fistula remained, she had control of the bowels, and was comfortable until a second operation, which was done two months later, which with two or three applications of lunar caustic completed a cure.

I was not told of the pre-existing vaginismus until after the second operation, when the husband gave me the previous history. He has since said that he thinks I sewed her up tighter than she was before, but that is not so. I think it is simply a return of the old condition. [Since writing the above, this patient has been pregnant for the second time, and passed through her confinement with only a partial laceration.]

CASE II. Last October I was called to attend Mrs. W—— in her first confinement. She was an unusually large and

well-proportioned woman, and had had comparatively little trouble during her pregnancy. As I was out when the call came, another physician was called in until I could get there. When I arrived, I found that gentleman very glad to have me take charge of the case, as he was disgusted with the way she acted, and remarked that he had never seen another case like it.

The pains were coming at intervals of about ten minutes, and quite severe, and to all appearances it was a case of ordinary normal labor. On attempting to make an examination, however, a curious state of things presented. On the slightest touch of the vulva she would cry out, and on pressing the finger into the vagina she would shriek and become rigid, almost going into a state of opisthotonus. I succeeded, however, in making out the presentation, which was vertex, and in the first position, and, suspecting what the trouble was, called the husband aside and questioned him very closely as to her previous condition. He informed me that connection had always been excessively painful to her, and almost impossible until she was three months advanced in pregnancy. After that she had had little trouble.

The pains soon began to be violent, and I put her just sufficiently under the influence of chloroform to dull the pains and to render her very drowsy between, but not enough to stop them. The head came down rapidly until it reached the perinæum, which I found so rigid that I began to fear trouble was coming.

I had a bowl of hot water and some towels brought, intending to make hot applications to the perinæum. The head had come down just sufficiently to separate the labia a little during the pains, and not expecting the completion of the birth for at least ten or fifteen minutes, I was not supporting the perineum, but was leaning forward getting a towel ready to wring out of the hot water, when suddenly a terrific pain came on, the patient gave a shriek, and, turning quickly, I was horrified to behold the head protruding

from the vulva. The rigid perinæum had given way before the force of the contraction, and had split clear down to but not through the sphincter ani. I extricated the shoulders and the rest of the child without further accident, but had a fine time of it afterwards with retained membranes, hæmorrhage, and stitching up the perinæum. As I could not reach any other physician to help me, my only assistants were the husband and an old German nurse; but, after a great deal of trouble, I managed to get in two deep sutures of silk, which, fortunately, were sufficient to effect good union.

These two cases are the only ones which have come directly to my notice as cases of pre-existing vaginismus complicating labor and resulting in lacerated perinæum. I am indebted to my friend, Dr. Edward J. Pratt, formerly resident physician of the Brooklyn Maternity, for the notes on a case in which vaginismus complicated labor, but which did not result in laceration. I give his notes:

"Maggie G—, *æt.* 18, single, primipara; entered Maternity in labor about 9 A. M., June 25, 1883. Vulva so hyperæsthetic as to make an examination impossible. At 6 P. M. gave chloroform, and found os well dilated. Labor advanced until the head reached the inferior strait, where it caught and remained three hours; then chloroform was again administered, forceps applied, and delivery quite easily effected.

"This is the substance of the history recorded, but I remember very well when she applied for admission some three months previous, I attempted to make an examination, but could not, on account of the vaginismus. She said that intercourse never occurred but once, and then very incompletely, which I did not doubt after the examination. She got up very quickly after her confinement, and no note is made of the condition of the perinæum, but there would have been had there been laceration to any extent."

The above case, as well as Case I. and the one noted by

Schroeder, shows how labor can be retarded by the rigidity of the parts. In the last case the perinæum was doubtless saved by bringing the patient into a completely anæsthetic state. I shall refer to this further on in speaking of the methods of prevention.

Vaginismus is a term first used by Dr. J. Marion Sims to denote a "painful spasmodic contraction of the mouth of the vagina,"* and he describes it thus: "By the term vaginismus I mean an excessive hyperæsthesia of the hymen and vulvular outlet, associated with such involuntary spasmodic contraction of the sphincter vaginæ as to prevent coition. This irritable spasmodic action is produced by the gentlest touch; often the touch of a camel's-hair pencil or a fine feather will produce such agony as to cause the patient to shriek out, complaining at the same time that the pain is that of thrusting a sharp knife into the sensitive part. This is worse in some than in others. In a very large majority, the pain and spasm conjoined are so great as to preclude the possibility of sexual intercourse. In some instances it will be borne occasionally, notwithstanding the intolerable suffering; while in others it will be wholly abandoned, even after the act has been repeatedly, and, as it were, perfectly performed."

In speaking of one case, referring to the cause he says, "I gave the opinion that it was a spasmodic contraction of the sphincter vaginæ, resulting from an irritable condition of the nerves which I could not explain." And again, "Indeed it has always appeared to me that the symptoms of vaginismus were neuromatous. However, my friend, Professor Alonzo Clark, one of the ablest pathologists in my own country, has frequently examined the vaginismus hymen for me, and could not find any enlarged nerve filaments running through it." Mr. Dawson says,† "Vaginismus is a term

* "Clinical Notes on Uterine Surgery," Sims.

† Diseases of Women.—Lawson Tait, F. R. C. S., p. 46.

which has been greatly abused, for it has been made to stand sponsor for a great deal of ignorance and insufficient examination. When the word was first coined by my friend Dr. Marion Sims, he evidently meant it to apply to those cases in which the orifice of the vulva is so hyperæsthetic as to render the patient wholly unfit for her sexual functions, but no other explanation can be offered than that of a mysterious spasmodic contraction of the sphincter vaginæ muscle. Even in such cases it can be regarded as a symptom and not as a disease * * * I have had a large number of cases sent to me as vaginismus * * * but I have always been able to find a more tangible cause for the patient's distress than the hypothetical contraction of the sphincter muscle. By far the most common causes of the patient's sufferings in these cases, are the fissures resulting from marital rents, or the too frequent intercourse resulting in excoriations of the nymphæ or chronic vulvitis. Other cases will be found to be due to painful warts, urethral caruncles, or patches of the vascular degeneration of the mucous membrane already described. This latter cause is especially frequent near the climacteric period, and a patch the size of a millet-seed will be found to give excruciating agony * * * Cases of true vaginismus may occur, but I must assert that as yet they are quite unknown to me." The opinion of Dr. T. A. Emmet is somewhat similar to that of Mr. Tait. He says: * "It (vaginismus) is to be regarded purely as a symptom denoting reflex irritation, of which the chief expression is an exaggerated sensitiveness about the hymen and the vaginal outlet. As the irritation is transmitted through the sympathetic nerves, the effect is experienced at its terminal branches in the erectile tissue distributed about the entrance to the vagina.

"It is found only in anæmic and excessively nervous women, and in those who have in some manner overtaxed

* Emmet's Principles and Practice of Gynæcology, p. 599.

their nervous systems. Their general condition renders them peculiarly liable to neuralgia, of which the symptom under consideration is but a kindred ailment. The locality is determined as if it were by accident, or by some law of which we are ignorant. It is the exception to find any local exciting cause; occasionally there may be some cicatricial tissue about the perinæum, or neck of the uterus, or some local inflammation or disease of the vagina, vulva, meatus, urethra, or vesical neck."

Dr. Emmet's experience does not coincide with that of Dr. Sims, who believed vaginismus to be a distinct local lesion. Carl Braun* says that one or several groups of muscles may be involved, making coition, exploration, the introduction of the speculum, urination or defecation impossible.

He mentions Hildebrandt as ascribing vaginismus to arise from two sets of causes, the first like those mentioned by Emmet, which gives rise to reflex symptoms, and second, a condition of general sensibility and nervous irritability, which may exist primarily, or what is more frequently the case, the same condition gradually resulting from an oft repeated, partial stimulation, and arising through an unsatisfied sexual appetite.

Dr. Wm. Tod Helmuth† says: "Women of a nervous temperament, of an emotional nature, are most likely to suffer from this affection, and it will be generally observed that with it are associated symptoms of spinal irritation."

Dr. R. Ludlam,‡ in whose work will be found one of the most interesting and complete articles on vaginismus, says: "The most cultivated and gifted women, those of a high moral or emotional nature, are most subject to this affliction. This is especially true of such of them as inherit the hysteri-

* *Lehrbuch der gesammten Gynækologie*, p. 375.

† *System of Surgery*, Helmuth, p. 898.

‡ *Diseases of Women*, Ludlam.

cal disposition * * * All this large class of women are exceedingly prone to be mismated, and to suffer from personal antagonisms which jar their sensibilities and derange the sexual sphere. Thus it may happen that a delicate, sensitive, impressible woman, who, if she were properly mated, would be exceedingly happy and contented, is tied to one whose brutal approaches become more and more loathsome and repulsive, until finally this morbid sensibility which ruins her health and happiness is developed." Dr. Emmet, speaking on this point, says: "There is a certain condition which is almost always accompanied by a moderate cellulitis in one of the broad ligaments, rendering the female devoid of all sexual desire. For a time, womanlike, she will submit to marital approaches through a sense of duty, but after a while, by degrees, their suggestion even excites a feeling of disgust. If she continues to submit to what she supposes she is obliged to do, this hyperæsthesia and spasm become developed as an earnest of the disgust, in the same manner as the gullet closes spontaneously against and rejects a nauseous draught."

In the consideration of this subject I have gone to some length to get the ideas of different authors in regard to it, as determining the cause will indicate the treatment which should, if possible, be carried out, and a cure effected before the time of parturition and thus avoid any bad consequences which might follow. It is probable that whatever causes the spasmodic contraction of the sphincter vaginæ during an attempt at coition will be all the more excited to action during the pain and nervous irritation attendant upon the passage of the child through the vaginal outlet.

It seems evident that the various authors mentioned have met with different experiences in regard to this disease, and have come to different conclusions. Dr. Sims seems to stand almost alone on one side, believing it to be a disease of the hymen alone, and generally curable by its exsection, while Tait and Emmet find it generally only reflex from

some other lesion. The other authors seem to have experiences combining those of both sides. My own limited experience has been more in accord with that of Dr. Sims, but not entirely so.

Dr. Emmet claims that the disease is found only in anæmic and excessively nervous women. Neither of my own cases were examples of this class; in fact, both seemed pictures of robust health. Dr. Ludlam says that although "the disease may occur in virgins, or those who have been married, it does not in those who have had a child or children." This is contrary to the experience of Dr. Sims in the case before cited, and to my experience in Case I., and in another case of mine where the patient had extreme vaginismus after three miscarriages at the sixth month. It is true that in the latter case it was complicated with vaginitis and cystitis, but what is curious is that this patient's mother suffered from vaginismus until after the birth of her second child.

There is no necessity of my relating the symptoms of vaginismus, as they are well known and sufficiently indicated in what has already been said.

Treatment.—Speaking of the curability of the disease, Dr. Sims say: "From personal observation I can confidently assert that I know of no disease capable of producing so much unhappiness to both parties of the marriage contract, and I am happy to state that I know of no serious trouble that can be cured so easily, so safely, and so certainly."

Without going into details, which can be found in the books, I will simply indicate the methods of treatment indicated by the different causes producing the disease. Dr. Sims' treatment was radical and consisted of complete excision of hymen, with incision of the vaginal orifice and subsequent dilatation. One objection raised to this method is the cicatricial contraction which is liable to take place at the site of the excised hymen. I should think that this might in a great degree be overcome by uniting the edges

of the mucous membrane after the manner employed by Dr. Emmet in his operation for making urethro-vaginal fistula.

Dr. Sims thinks gradual dilatation without removal of the hymen worse than useless, while other gynecologists report cures as made by this method. Dr. Ludlam recommends the use of an ointment of extract of belladonna to six parts of simple cerate to be used on the bougies which are used for dilatation. At the same time he recommends proper diet, the regulation of the habits and the complete interdiction of coitus until a cure is completed. Warm baths and electricity are good auxiliaries. As homœopathic to these cases he advises the use of such remedies as "belladonna, atropine, thuja, macrotin, sepia, cocculus, conium, platina, nux vomica, pulsatilla, hyoscyamus, ignatia, and mercurius." Where the cause is a fissure resulting from marital rents, or excoriations of the nymphæ from too frequent intercourse, Tait recommends only the use of simple cerate and the restriction of intercourse within moderate bounds. Painful warts and urethral caruncles should be excised, while patches of vascular degeneration of the mucous membrane may be touched with carbolic acid and then covered with cerate.

Anal fissures should be treated by incision through their base and light cauterization, regulation of the bowels, etc. Cellulitis, ovaritis, and other exciting causes should have appropriate treatment by the use of hot douches and other local and constitutional remedies. Of course, if the husband is found to be the exciting cause he must be properly regulated.

But suppose that we are called to a case during labor without a previous knowledge that the patient has been suffering from vaginismus, and there has been no time for preparatory treatment, I have not had an opportunity to demonstrate that remedies will relieve these cases.

It seems to me that when the condition is found to

exist during labor that there is but one resource, and that is to place the patient in a state of complete anæsthesia so that the sphincters shall be thoroughly relaxed. Chloroform is the favorite anæsthetic during labor, but is much less safe than ether, while ether has a greater power of relaxing the sphincters. I have more than once noticed complete relaxation of the sphincters and vagina during ether narcosis, and have seen the anus stand open to such an extent that the largest sized blade of a Sims' speculum could be placed within it. I think by this means the laceration of the perinæum may be prevented, and subsequently, if the vaginismus still persists, it can be treated according to the indications.

SURGICAL TREATMENT OF UTERINE DISORDERS.

BY L. A. PHILLIPS, M. D., BOSTON.

The consideration of our general subject, viz.—Treatment of Uterine Disorders—without including surgery, would be (to use a familiar illustration) like the play of Hamlet, with Hamlet left out. Yet as gynæcologists of the new school, we stand between the two extremes of opinion regarding the sphere, the limits and the relative claims of this branch of treatment as applied to the diseases of women. While our old school brethren would make surgery the chief and almost the only means of treatment, the extremists in our own ranks would have us ignore all other than the simple therapeutic method. "Between the extremes lies the truth" is, we believe, applicable to this, as to most other questions, and this I shall endeavor to maintain and make evident in what is to follow, and inasmuch as it is to the representatives of the therapeutic, not to those of the surgical extreme, I speak, my arguments will be chiefly against their position.

While we may all admit that, ignoring all practical appli-

cation of the theory, it would, from an idealistic standpoint, be far more satisfactory if all ills to which flesh is liable, *could* be relieved and cured in the one ideal way, *i. e.* by the administration of the indicated therapeutic remedy, yet in actual practice, we must insist that it is not right or even excusable to continue administering one or various drugs which are hoped to be remedies, year after year, for symptoms which are dependent upon some abnormal condition that an appropriate surgical operation would remove and cure in a few days or weeks. Yet that this is done in many instances cannot be truthfully denied.

It is claimed, and from the old school experience at least can easily be maintained, that surgery has done more for the prolongation of life, restoration to health, and consequent increase of the comfort and happiness of women afflicted with uterine and ovarian diseases and disorders, than any or all other means; and to ignore a method of treatment which has accomplished so much as has modern gynæcological surgery, is as unwise and as unreasonable as, on the other hand, to ignore all else but surgery. As homœopathic gynæcologists it remains for us (and I wish it might be made a fixed purpose) to demonstrate the superiority of a wise and consistent combination of surgical with therapeutical measures, over either unaided by the other. In order to do this effectively, so that it cannot be denied or gainsaid, we must all recognize several conditions as essential and absolutely necessary.

Among the first in importance is a careful and exact *diagnosis*. It cannot be reasonably asked or expected that any credence will be given to our reported successes in any direction unless we can show that our diagnoses, upon which our claims must be founded, are something more than guess-work. We must be able to establish beyond a reasonable doubt that the disease or condition we treat and cure had an actual existence in fact at the outset; and to do this we must show that the evidences of such condition, as generally

recognized, were known to be present. Neglect, or rather defiance, or the ignoring of this requirement by some among us, has rendered their reports of cures by therapeutical or other means unreliable and practically without weight or influence, even though they may, in some instances at least, have been true cures, and not only are the value and influence of such reports thus destroyed, but unnecessary and much to be regretted animosities and hard feelings have been the result. It should, however, be realized, that doubting or even denying the credibility of such reports, involves no charge of dishonesty against the reporters, but simply a doubt of the existence of conditions which all but human experience pronounces improbable if not impossible. In any field of inquiry under such circumstances absolute proof is and must be demanded. A mere opinion, however honest, without evidence is not proof. Even if we care for nothing but the subjective symptoms as a basis for our prescriptions, yet the diagnosis is absolutely necessary to the establishment of any claim to the cure of any pathological condition. Let us therefore accept this condition and thus be able to prove our claims. Another condition requisite to any marked success in our object is unity of purpose, concert of action, and mutual co-operation among all the members of our own school. To bring this condition about is one of our greatest difficulties, because one element acknowledges no necessity for any other examination than by questioning and of no other treatment than medicinal, hence they neither know nor care whether their patients might be cured by surgical aid or not, and if they did, would do like the second class, who, while they try to ascertain by proper examination what conditions they have to deal with, still choose to experiment, procrastinate and palliate with the hope or perhaps the belief that in time a cure may be thus effected, rather than refer them to any other physician—and still others when they can hold such patients no longer will either send them or allow them to drift into the hands of

old school specialists, which leads them very naturally to believe that homœopaths are incapable of giving the needed surgical aid. Now I claim that surgical work is being done by homœopathic gynæcologists throughout the United States which will bear comparison with that of any others, and that it should command the confidence and win the hearty recognition and support of all who desire to see the superiority of homœopathy demonstrated, but the false idea to which our enemies and opponents would, if they could, have us all restricted, viz., that the homœopath must do nothing except what he can do with homœopathic therapeutics—this idea unfortunately possesses a considerable portion of our number—hence their entire lack of recognition and support of the surgeons and specialists among us. To destroy this false notion, and effect a change of opinion in this matter we should employ all honorable means within our reach, make all possible effort to convince our brethren of the fact, regardless of any personal interest we may individually have in it, that the best interests of the cause they all love as well as those of themselves and their patients, demand a due recognition and application of surgical with therapeutic treatment. Furthermore, all who would be active workers in proving the claim to superiority of homœopathy with surgery as in all other fields of operation, must spare no effort or pains to perfect themselves as operators, and make their work equal to the best; and what is of no less importance, yet quite as likely to be neglected, we must strive to make the homœopathy which we combine with surgery equal to the best also.

Under these conditions and upon this basis we may fairly expect and demand recognition and the accomplishment of our purpose as homœopathic gynæcologists. I desire now to indicate some of the conditions which demand surgical treatment, and others in which it should at least be considered as an alternative, as also what should be accomplished by the operation in some of these cases, yet without detail-

ing any of the special operations which are familiar to those who perform them, and of little interest to those who do not.

When there has been, from parturition or otherwise, such injury to the cervix uteri that instead of a normal os we find a gaping slit, especially if the lips are everted and the cervical endometrium inflamed and eroded, and with these local evidences are associated various nervous disturbances of greater or less intensity, which may be, and probably are, dependent upon the injury, surgical repair—restoration of the injured parts to their normal form and relations, offers the only means of removing the cause of trouble. When cicatricial tissue is present it should be all removed, and when cystic degeneration has taken place it is important that all the unhealthy tissue be pared out, even if the normal form and size of the cervix are thereby sacrificed. Then, the exciting cause of nervous disturbance having been removed, the remedies variously indicated have a chance to effect a cure, which careful observers generally believe impossible without surgical aid; and certainly no one will pretend that the injured organ could be made to unite and assume a normal condition through the influence of medicine alone, even if they could by such means temporarily control and palliate the reflex symptoms. When epithelioma, especially the proliferating variety or cauliflower excrescence, can be discovered in its early or incipient stages, thorough and complete removal of all the diseased tissue is the sole and only means of cure, and this must be done before the disease extends to tissues which cannot be removed, and before there has been any considerable breaking down of tissue, so that through absorption the lymphatics are impregnated with the malignant material. I do not say that this must be done by the knife alone. In fact, I think it is best done by the combined use of the knife and chloride of lime, as the latter is not only an antiseptic, but it seals the absorbent vessels against all poisonous matter.

Polypoid growths, which often cause much alarm, espe-

cially through hæmorrhage, and which are so easily removed, should be cut away or curetted off, and then the remedies to prevent the further development of such growths have their fitting place. The same may be said of fibroid growths, when their location is such that they can be readily and safely enucleated, especially if they are productive of excessive hæmorrhage or discomfort, such e. g., as sometimes results from mechanical pressure against the bladder or rectum. Even when the growths are too large, or so unfavorably situated that their removal in this way is impracticable, if serious hæmorrhage or other urgent symptoms demand active efforts for relief, surgery still furnishes a means of controlling, if not of wholly removing, the difficulty. Removal of the uterine appendages, which is attended with comparatively little danger to life, is generally effective in arresting the hæmorrhage, and also the development of these growths, while as a last resort hysterectomy may save many lives which no other means or measures could materially aid.

In the treatment of uterine displacements surgery should sometimes be applied. Alexander's operation or some of its modifications for shortening the round ligaments, and thereby drawing the fundus uteri upward and forward is, I believe, a practicable and effective method of curing many otherwise intractable and distressing cases of retro-flexion, retro-version, and prolapsus. In the latter condition it should supplement the repair of the perinæum when that is required, for without retro-version, which this prevents, prolapsus is well nigh impossible.

It must not be expected, however, that even this method of treatment will render future displacement impossible. We would not claim to so improve upon nature that, if the causes which previously produced the displacement were again applied, they would be unable to effect any displacement now.

Without referring to other operations upon the uterus itself, or those for diseases or injuries of other related organs, from repair of the perinæum to the removal of ovarian

tumors, with all the wonderful record furnished by modern gynæcology, it must, I think, be evident to all, that with all these many directions in which we may relieve and cure uterine diseases by surgical treatment, when some, at least, are incurable by any other known means, no physician can treat this class of cases for any considerable time unaided by surgery without in many instances either failing to learn what is needed, or knowing this, ignoring the means which would most surely and most speedily accomplish the purpose, and in either case doing great injustice to his patients by needlessly prolonging their ills and bringing reproach upon himself, and to no small extent upon us all as members of the school of practice which he is supposed to represent.

It will be claimed, perhaps, that by other means than surgical all these cases might eventually be cured, but the weight of evidence is all against such a claim, while if admitted, it is but substituting a slow and uncertain process for one which is almost sure and immediate in its effects. But in most of those cases which are properly surgical, even when by medicinal treatment the symptoms, *i. e.*, the effects of pathological or traumatic conditions are relieved, no cure can be justly claimed, only palliation; inasmuch as while the cause still remains the effects will reappear unless continuously palliated, and this cause is most severely condemned by these same men, even when applied to cases which neither surgery nor medicine can cure, but where suffering may be somewhat relieved by palliation, hence this course appears inconsistent as well as unjustifiable.

In conclusion, that I may not be misunderstood, let me assure you that in all I have said of and to those who do not recognize or feel the need of surgical treatment in gynæcology, my object has been not to arraign them in judgment or even to criticise or find fault, but merely by argument and illustration to convince them, if possible, that they are rejecting an aid which is in no sense destructive to or inconsistent with the true therapeutic method, but, instead, is

one of the very means through which to establish and demonstrate the principles for which they are so strenuously contending, and I feel confident that if this fact is recognized then one and all will earnestly and harmoniously unite with us in our effort to demonstrate the advantage of homœopathy in the field of surgical gynæcology, as well as elsewhere.

AN INQUIRY INTO THE CAUSES OF THE FREQUENTLY UNSATISFACTORY RESULTS OF REMOVAL OF THE UTERINE APPENDAGES, WHEN THIS IS DONE TO RELIEVE PELVIC PAIN.

BY H. I. OSTROM, M. D.

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In certain cases of severe pelvic pain referable to the ovaries, or the tubes, the removal of the uterine appendages is a justifiable operation, and one resting upon sound surgical principles; but it is undeniable that, though the operation may be indicated, and as a surgical procedure perfectly successful; though the patient may recover from the mutilation and manipulation with scarcely a rise of temperature, and with no untoward symptoms, in many instances, viewed as a curative measure, the removal of the uterine appendages must be considered to have failed to accomplish all that we had promised ourselves it would accomplish; have failed to relieve the pain that we had every reason to believe was centered in the parts amputated. We are therefore led to ascertain the causes of our disappointment.

In the first place, I wish to distinguish between the class of cases here referred to, and another class in which the operation is also performed. They are widely different;

and the ends sought are entirely dissimilar, though the operations may be almost identical. I here refer to the removal of the uterine appendages for the relief of persistent ovarian pain; dysmenorrhœa, that depends upon a more or less diseased state of the oviducts; and the succession of symptoms that we have learned to associate with the different stages of inflammation of, and about the tubes and the ovaries. Removal of the appendages for the purpose of arresting the growth of uterine myoma, does not form a part of the present inquiry.

The diseases of the ovaries that give rise to such a degree of suffering as to resist other means of treatment, and that make their removal necessary, are either of specific origin, or arise from some error in the functional activity of the reproductive organs. From either cause, the local pathology is represented by congestion, inflammation, adhesions, and suppuration. Practically, therefore, the conditions for which we most frequently remove the uterine appendages are the result of inflammation, and of these results, adhesions and consequent connective tissue thickening, and new formation, with the involvement of nerve fibers, constitute by far the largest proportion.

The physiology, and the anatomical relations of the ovaries and Fallopian tubes, are favorable to the development of pain, and to its persistence, as a result of inflammation. If the connective tissue of the ovary becomes thickened—from inflammation—the physiological tearing of its envelope, which takes place when a Graafian follicle is ruptured, or the futile attempt at tearing, must give rise to intense suffering, with which all the pelvic organs sympathize. By frequent repetition of the causes of the inflammation, and its physiological aggravation, the pelvic organs become diseased, and the effect may remain long after its cause has been removed. It is therefore probable that inflammation, having its origin in the ovaries or tubes, is not long confined to these organs, but appears in contiguous structures, either as a continua-

tion of the original pathology, or is in them protracted as one of the effects of that pathology.

The situation of the uterine appendages is conducive to the involvement of secondary structures to such an extent as to render them independent of the primary lesion. This is especially true of the left ovary, lying as it does on the rectum. The gland on this side is more frequently diseased than the right ovary, not only because of its close relations to the lower bowel, but also because of the peculiar valveless struction of its vein, an anatomy that finds its analogue in the left spermatic vein in the male.

Now, what I wish to emphasize here, and advance as one of the causes of our failure to relieve pelvic pain by removing the appendages, is, that at the time we operate, the pain area is not always bounded by the appendages, but has spread beyond these, its original seat. Removal, therefore, of the ovaries and tubes in such cases will not be followed by permanent relief from suffering, for the operation does not include all of the diseased structures. It may well be questioned whether it is possible to remove the entire pain area when the pathology has spread beyond the ovaries and their ducts.

Now, upon the belief that the pathological condition of peritoneum, intestines, pelvic nerves and organs generally, which had its starting point in the appendages, may become so well pronounced as to be capable of indefinite continuance after the appendages are removed, it becomes evident that such cases are not ones in which Mr. Tait's operation can be done with any prospect of effecting a cure. The functional activity of the ovaries and tubes must always act as a stimulus to any pelvic pathology that is connected with them, and of course the removal of that stimulus will take away the periodic attacks of pelvic congestion; but the operation as proposed by Mr. Tait will not relieve the suffering for which in such cases it is performed.

How can we discriminate without the aid furnished by

the crucial test of an operation, between a case that will be cured by removal of the uterine appendages, and one that does not justify such an operation. Until our knowledge of the pathology of the ovaries and their oviducts is more perfect, I know of no indications more trustworthy than those furnished by the effort of menstruation upon the pelvic lesion. The physical signs of adhesions, and connective tissue infiltration, will not alone be of determining importance, for these may exist to a marked degree, and give rise to comparatively little discomfort. It is probable few women of to-day that have been pregnant, have escaped some degree of pelvic peritonitis, or are free from evidences in the region of the appendages of some form of inflammation, yet many of these women are not conscious of disease, and do not suffer inconvenience from their pelvic derangement. But the group of symptoms furnished by menstruation, that is, the subjective effect of the periodic activity of the ovaries and tubes upon the local inflammation, is conclusive evidence either that they alone are the cause and seat of the suffering, in which case their removal would be followed by relief; or the local suffering being only increased during that period, not limited to it, furnishes us conclusive proof that the pathology has spread beyond the uterine appendages, that the contiguous tissues have become neoplastic and self-supporting, and that removal of the appendages will not be followed by an entire relief from pain and pelvic derangement. With such a history, nothing less than removal of the entire diseased structures would be followed by a permanent cure.

It will be understood that I do not here speak of simple adhesions the result of inflammation; those may be very dense, so much so as to render the removal of the uterine appendages among the most difficult procedures in abdominal surgery, and still the operation be indicated and be followed by success. I refer rather to the organized connective tissue that binds the Fallopian tubes, the ovaries, the

broad ligaments, the neighboring intestines, and it may be the uterus, in one firm and common neoplastic mass, involving nerves and interfering with function. I do not believe that such cases are proper ones for operative surgery, and any attempt to remove the uterine appendages under such conditions will be followed by failure to relieve suffering, if happily this is not thereby increased. I am therefore inclined to limit the removal of the appendages in oöphoritis, which also may include inflammation of the tubes, to the cases aggravated at menstruation, or those in which the suffering is confined to that period. My experience leads me to believe that such cases do not have their origin in gonorrhœa—as many cases of oöphoritis unquestionably have—but are frequently the result of excessive or irregular sexual relations, or as in a case that I operated upon about a year ago, of ungratified sexual desire; they also not infrequently have an etiology that involves some disorder of parturition. Observations, however, upon these points, require further confirmation to invest them with value. But I do not believe that every case of inflammation of the ovaries has a specific origin any more than I believe that every case of inflammation of the testicles can be referred to the same etiology. Inflammation of a specific nature is probably represented by the most serious cases of pelvic inflammation, for the gonorrhœal pus has nothing to limit its infectious qualities after it has gained access to the abdominal cavity. I do not believe that such cases, excluding of course those complicated by suppuration, which must be treated as collections of pus always should be treated, by evacuation and drainage, are cured by removal of the appendages. The history of many of such operations is, for a time, while possibly recuperating from the laparotomy, the patient is free from acute suffering, but soon the pelvic pains return, with possibly an increase from adhesion of the pedicle, or adhesions of the intestines to the abdominal wound.

Our method of dealing with the pedicle, and with adhesions, has seemed to me a possible cause for some of the failures to relieve pelvic pain by removal of the uterine appendages. The majority of operators trust to the ligature for this purpose, but in the ligature they include nerve as well as vascular tissue; and while it may be said in defense of this method that the ligature probably early ceases to constrict, and hence the effects can not be lasting, I think it can be shown that any considerable pressure of tissues, such as that used to control hæmorrhage, may leave more permanent changes than those that end with the actual constriction. Then, again, we can scarcely question that there is an anatomical choice of parts out of which to construct the pedicle, this choice relating to the nervous supply of the structures included within the ligature. We find, for example, that the surgical pedicle of the ovary is not anatomically the best place at which to ligate it, for it is there, at the hilum, that the spermatic nerves enter the gland. A ligature applied to the bulb of the ovary will constrict erectile tissue, and the nervous supply of the gland. The Fallopian tubes are not as rich in nerves as the ovaries, neither are the broad ligaments. A ligature, therefore, applied to the broad ligament below the ovary, and made to include the oviduct as close to the horn of the uterus as possible, not only secures a good pedicle, but also, and in the present connection this is of the most importance, avoids constriction of the spermatic nerve as it enters the ovary. I am not aware that any statistics have been published bearing upon the relation between the relief of pain after removal of the ovaries only, and the relief that has followed removal of the entire appendages; it is therefore hypothetical on my part—for I have been unable to gather such statistics—that the most successful cases will be those in which both ovaries and tubes are removed; that with the complete operation, there is more prospect of securing permanent immunity from pain, even though the ovaries

only require to be amputated. Does not Tait's operation, therefore, when amputation is necessary, promise the best results? After the ovaries are removed, the tubes are useless, and while their removal with the ovaries may increase the difficulties of the operation, the risk is not thereby augmented.

But when we have sought an anatomical pedicle, and ligated it, and when we have ligated dense adhesions, we then must meet the difficulty of constricting nerves, and more or less unnecessary tissue. Much of Mr. Tait's remarkable success in abdominal surgery depends upon his method of treating adhesions with dry sponging. He will sponge away adhesions that another surgeon would ligate, and he will frequently control hæmorrhage in the same way. It is probable that we resort to the ligature with uncalled for haste; that sponging and the actual cautery are many times sufficient to control hemorrhage. I do not believe that we use the cautery as much as we should use it; it will often most advantageously take the place of the ligature, and when the latter is necessary, will assist in rendering less permanent the effects of the constriction which it produces.

I have thus far referred only to the causes that may interfere with the success of the removal of the appendages, so far as the relief of the suffering which leads to the operation is concerned. It is possible that in this sense the operation may be successful, and still the patient continue to suffer, possibly for the remainder of her life. We must then look to the method of operating, and ascertain if our manipulation has developed new processes that could give rise to pelvic pain. A knowledge of these must be obscure. They will, however, have no indirect relation to inflammation, and inflammatory adhesion.

It is the custom of some surgeons to allow their assistants, and to invite those present at the operation, to examine the abdomen after he has made an examination, and before

any attempt is made to remove the appendages. Such a practice is unnecessary. The operator is sure only of his own fingers, and if he cannot with them make a diagnosis, and decide when, and what to do, he should not have opened the abdomen. Then, again, some operators will examine first one side, and then the other, several times, with the necessary withdrawal and reintroduction of his fingers. Such maneuvers do not impress one with the skill of the operator, and increase the mechanical risk of the operation. Only the operator's finger should enter the abdomen, and in the majority of cases, his exploratory examination will also be the one by which he brings the appendages out for ligation. Undue manipulation of the abdominal contents cannot be too strongly discouraged; its necessity must be looked upon as an unfortunate complication of any case.

To prevent adhesion, the undoubted source of much of the persistent abdominal pains after laparotomy done for any purpose, it is of the utmost importance to remove all organizable material from the surface of the peritoneum. Therefore the toilet of the peritoneum bears no indirect relation to the results of the operation, and in the toilet, drainage fills a prominent place.

The disadvantages of leaving the abdomen open for drainage are not to be disregarded, and not every case will be required to be so treated; but on the other hand, we must not be unmindful of the benefits derived from providing some means of removing material that is capable of organization, from organs that establish adhesive relations very readily. To decide for, or against drainage, requires skill and experience, but in general, we may say, that if any considerable cleansing of the abdomen is necessary, it is wise to establish good drainage for at least forty-eight hours, when, if the peritoneum is dry, the tube may be removed, and the wound closed. If we have controlled all oozing from the torn and cut surfaces, and sealed them with the cautery, we may assure ourselves with some confidence

that thorough washing, and therefore drainage, are not essential. But we can not often accomplish this, and as long as our sponges shows even a discoloration, we should irrigate,—water poured from a pitcher, is more effective than when allowed to run from the usual cistern—and if this seems likely to continue despite washing and sponging, the indications for drainage are clear.

The few causes which I have indicated as contributing to the failure to relieve pain, which every laparotomist has encountered, do not exhaust the list of such causes. I have confined the present inquiry to those which, in my experience as an operator, have seemed to be the most frequently active.

WHOOPIING-COUGH.

BY THOMAS NICHOL, M.D., L.L.D., D.C.L., MONTREAL, CANADA

V.

Corallium rubrum was introduced to the notice of our school by Dr. Alphonse Teste, of Paris, who writes:—"From the moment that the coughing fits have assumed the convulsive form, and even before that time, that is to say, during the catarrhal period; as soon, in a word, as one is sure of having to deal with a whooping-cough instead of a simple bronchitis, we should immediately prescribe *coralia rubra* of the thirtieth dilution, for three or four days in succession, four doses in the twenty-four hours." "It is like water thrown upon fire," said one of my patients to me one day after I had given him this medicine for attacks of a convulsive cough which had passed into a chronic state." Many excellent observers support Teste in this application of a little-known remedy, and though subsequent experience has not secured Teste's splendid results, this remedy now holds a recognized and well-defined place in the therapeutics of whooping-cough. Bayes writes: "In the second and third stage of whooping-cough, occurring in tuberculous subjects,

I have seen good results from corallium thirtieth in allaying the violence of the cough. Hughes says he once treated a family of children on Teste's plan, and they certainly all had the disease very mildly ;" and Harry Thomas says that it proved of great benefit, for four cases out of twelve in which it was used, were entirely cured by its administration, and the remaining eight mitigated in their severity. In my own experience, it has only been curative in tuberculous or scrofulous children, and I incline to think that this is the leading inclination, and that in simple uncomplicated whooping-cough. Corallium is not of equal value with cuprum, ipecac, belladonna and some other remedies.

Kafka remarks: "In the hyperæmic form of whooping-cough corall. rubr. may also be applied, if the hyperæmic phenomena are so intense as to make one fear the development of meningitis," and a reference to Allen's Encyclopædia of Pure Materia Medica bears out this suggestion. The corallium whooping-cough consists of fits of exceeding loud and violent cough, commencing with gasping for breath and continuing with repeated crowing inspirations, till the child gets purple and black in the face; worse in the latter part of the night, and in the morning; the larynx and trachea are more involved than the chest; the mucous membrane of the throat and chest are very sensitive, and change of air sets the patient coughing; loss of appetite and thirst; severe fits of coughing followed by a loose cough, with vomiting of quantities of tough, ropy, stringy mucus; during the interval between the paroxysms, the patient is very much exhausted, either lying down in a state of half-stupor, or lolling listlessly about.

I have never heard of corall. being used lower than the thirtieth dilution, possibly still better results could be obtained by the use of the two hundredth.

Coccus cacti is mostly used during the second stage of the disease; suffocative cough, with expectoration of much tough, ropy, white mucus, which accumulates in the chest

and throat, and is difficult to raise, almost causing strangulation and vomiting of food; worse during night after going to bed, after remaining long in one position, also when entering a heated room, after having been in the cold, open air; cough worse on first waking, which racks the system all over; the head pains as if it would split, while the face is purple; protracted bronchial catarrhs remaining after whooping-cough. Urinary difficulties are often present, and the child feels better in the open air. I have had no personal experience with this remedy, but would advise the use of the sixth decimal dilution after each paroxysm of coughing.

Hartmann writes: "A medicine which is too often neglected by homœopathic physicians, because its curative powers are less apparent than those of our polychrest medicines, and which is very useful in the catarrhal stage, is squilla 15th or 18th. Independently of its known curative virtue in affection of the mucous membrane and glands, the catarrhal symptoms are frequently of such a nature as to require its use: internal chilliness with internal heat, or *vice versa*, heat which is followed by chilliness on exposing one's self ever so little, and a hard and tense pulse, are permanent symptoms in every catarrh, especially when it has fluent coryza accompanied by a good deal of sneezing, and dimness of sight, with lachrymation. The selection of a drug is after all an inference of the reason, for the resemblance of the physiological symptoms to the phenomena of the natural disease is never perfect, were it only for this reason, that the natural disease runs its full course, with all its natural terminations, and that the drug disease is only a vague, indistinct indication of the natural type. Squilla is certainly indicated by a loose cough with expectoration, preceded by a rattling in the air-passages, and accompanied by a distressing pressure under the sternum and stitching pains in various parts of the chest. The catarrhal stage of whooping-cough is frequently much more

severe than a common catarrh; the accompanying fever has generally an erethic character, and sometimes rises even to the rank of a synocha with pleuritic stitches. Under such circumstances squilla is undoubtedly an appropriate remedy."

The cough of squilla, which is excited by drinking cold water, consists of violent, short paroxysms, with difficult expectoration in the morning of whitish or reddish-colored mucus of a repulsive sweetish taste; violent acrid coryza; the eyes are full of water; rattling of mucus in the chest, sneezing and involuntary micturition with every fit of coughing; absolute lack of sweat; the morning cough, with its expectoration, is far more exhausting than the dry evening cough.

Hartmann recommends the fifteenth or eighteenth dilutions; I have done well with the sixth decimal.

Dulcamara is quite similar to pulsatilla, and has been recommended if the attack is apparently brought on by exposure to cold and damp. This alone, it is evident, could never cause true whooping-cough, and it would be more correct to say that it is a remedy for a marked catarrhal state which may resemble the first stage of whooping-cough, for I have never seen any good effects from dulcamara in the fully developed disease. Hartmann writes: "In damp and rough fall weather, when the epidemic whooping-cough is not very prevalent, catarrhs are sometimes characterized by the following symptoms: Distressing oppression of the chest; the children become cross, do not like to play, are apt to have a fever, and during their sleep, which is restless, they constantly grasp at their chests; larger children complain of pinching in the chest, and endeavor to rub it away; there is catarrh with slight hoarseness, and a short, hacking cough; the pains are generally worse at night, accompanied by heat and thirst followed by chilliness. These symptoms, if recent, will yield to dulcamara 12th; if they should have lasted a while, other remedies will have to be used with the dulcamara, which is still indicated. The dulcamara makes

the cough loose, removes the hoarseness, and as a consequence the oppression of the chest, and diminishes the nocturnal exacerbations." But this accomplished therapist does not recommend dulcamara for whooping-cough, and indeed its pathogenesis points to no such use.

The dulcamara cough is loose, with copious secretions of mucus in the larynx and trachea, attended by copious, easy expectoration of tasteless mucus, and often of florid blood. The cough may be coincident with the sudden disappearance of a rash, and it is worse from taking cold, getting wet, or in damp weather.

Hartmann recommends the twelfth dilution ; I have never used it higher than the sixth decimal.

I have seen striking results from chamomilla, especially if given early in the catarrhal stage, when the constant irritation in the region of the larynx, inducing a dry, tight, hollow, suffocating cough, is accompanied by a crampy sensation, or when the cough is excited by a titillation under the sternum in the upper part of the chest. Hoarseness is present, and tenacious mucus is expectorated with difficulty, followed by a feeling of soreness at the part from which the mucus seems to have been detached. A wheezing, rattling noise is heard after every inspiration, as if the trachea were full of phlegm; this râle disappears after coughing. The paroxysms of cough are excited by an almost constant irritation in the windpipe, and the scanty, tenacious sputa are expectorated during the day, but none at night. I have noted a kind of spasmodic stricture across the chest, and often the child seems insensible for a little time after the cough. A good deal of fever is present, one cheek is red and hot, while the other is pale and cold, and there is warm sweat about the head. The child is very cross and wants to be carried all the time, and the crossness keeps up the cough, while, on the other hand, the cough aggravates the crossness. Diarrhœa is often present; green, watery, corroding stools, smelling like rotten eggs;

and Hartmann explains that at night this state of things is worse. The children have to be taken up a good deal; this exposes them to taking cold, and the cough brings on a diarrhœa and colic, which makes the children draw up their legs, kick with their feet, etc. The cough is worse in windy weather and from emotions, and is relieved by becoming warm in bed.

Almost by common consent the thirtieth centesimal is the standard dilution of this remedy. I have, it is true, seen good effects from the twelfth decimal trituration, but I have seen still better from the two hundredth.

Conium is often indicated when veratrum, though apparently indicated, has failed to relieve the distressing vomiting and nocturnal cough. The conium patient is usually scrofulous or anæmic, and Hartmann remarks that it is particularly suitable after measles. The cough is exceedingly violent, spasmodic and suffocative, accompanied by cerebral hyperæmia, flushed face; difficult, bloody expectoration; followed by vomiting of phlegm or of the contents of the stomach. Conium has been too much overlooked, but it is really an admirable remedy. I have always used the thirtieth dilution.

Pulte says that mercurius solubilis is "the principal remedy, where the child bleeds profusely at the nose and mouth when vomiting, with copious sweat at night, and great nervousness." The dry, fatiguing, spasmodic cough is mostly at night, and occurring in two successive paroxysms which follow each other in quick succession, after which there is a considerable interval of repose; at night without, in the daytime with expectoration of a thin, acrid, yellow, purulent mucus, often mixed with bright blood, of a repulsive or saltish taste and of offensive odor; bleeding from the nose and mouth with every coughing spell, and the blood soon coagulates. The fever resembles influenza, the patient is hoarse, with watery discharge from the nostrils; profuse nightly perspirations, which do not relieve. Hernig says

that mercurius is especially suitable for children who have suffered from worms. I have had the best results from the sixth decimal trituration, given dry on the tongue.

Phosphorus is not so much a remedy for whooping-cough as for some of its most dangerous complications. It is our chief reliance when bronchitis, broncho-pneumonia or pulmonary congestion are developed in the course of whooping-cough, especially during the third stage. There is hollow, hacking, spasmodic cough, excited by tickling itching in the chest, with expectoration during the day of tough whitish mucus, or else rust-colored or bright-red frothy blood, much hoarseness, almost complete loss of voice from the effects of the cough, which loosens with difficulty; burning, piercing soreness and tension in the chest; restlessness and clammy sweat at night. The patient is weak and anæmic, and the prompt use of phosphorus may prevent the development of phthisis. I think the dilutions from the 12th to the 30th most suitable, though some cases may call for the 6th decimal.

There have been more opinions, and more discordant opinions, concerning *carbo vegetabilis* than about any other of the whooping-cough remedies, not even excepting *drosera*. Pulte states that it is the principal remedy when the cough exhibits the first signs of whooping, and Jahr gives it if the first attacks of the spasmodic cough set in without vomiting, especially in the evening or morning. Hartmann tells us that "if neither of the above-mentioned remedies (*drosera*, *aconite*, *dulcamara*, *pulsatilla*, *chamomilla*, *nux vomica*, *squilla*, *belladonna*) should be able to prevent the irruption of the second or spasmodic stage, *carbo vegetabilis*, 30th, may yet be able to accomplish this," and with him agrees Laurie, who remarks that "*carbo vegetabilis* is frequently useful in bringing the convulsive stage of the affection to an early and successful termination after the previous use of *veratrum* or *drosera*, or both these important remedies; particularly when, notwithstanding the decrease of cough,

the tendency to vomit still remains." Hernig tells that "carbo vegetabilis is the chief remedy in spasmodic attacks of cough occurring twice a day, especially in the evening or forepart of the night," and he adds that "this is also one of the best remedies in the latter stages of the disease, after the more violent paroxysms are subdued." Finally, Kafka rejects it as a remedy for the whooping-cough itself, but advises it in a somewhat rare complication. He writes: "If the paroxysms set in with extraordinary anguish of suffocation, and the children, after the attack, are so prostrated as almost to faint, if they tremble over the whole body, and simultaneously there is meteorismus, and the gas, accumulated in the intestines, passes neither by ructus nor flatus, we give carbo vegetabilis, from three to four drops, in solution, and direct a dose to be given every two hours. This remedy is less reliable; it acts only symptomatically, removing the troubles mentioned, yet without directly affecting the attacks of coughing."

The cough of carbo vegetabilis occurs chiefly in the evening or before midnight. It is dry, short, hard, but infrequent, and is excited by a creeping irritation in the pharynx and larynx; coryza and hoarseness, which may pass into aphonia; rawness in the chest, with shooting pains; at times the cough is so violent and the irritation so constant that the patient has no relief until retching and vomiting have eased him; in the evening without, during the day, gray, greenish, sometimes purulent expectoration of an offensive, sour taste. The patient feels cold and chilly, and the temper is despondent and irritable; painful stitches through the head would be an additional indication. Hartman tells us that "a cough with mucous expectoration and painful pressure on the chest, resulting in vomiting of mucus, and followed by a stitching headache, is a proper indication for carbo vegetabilis."

I have tried all preparations of this remedy, from the blackish-gray of the first decimal trituration up to the myths

of cloud land, and as a result of my experience I conclude that the thirtieth dilution is the most generally useful.

Chelidonium, like corallium rubrum, was introduced by Alphonse Teste, who writes: "As soon as the amelioration produced by coralia ceases, that is to say, at the end of four or five days at most, it should be discontinued, and chelidonium majus administered, of the sixth dilution, three doses in twenty-four hours, and continued, unless there is a renewal of the violent spasmodic coughing-fits or convulsions in young children, or spasms of the glottis" (all of which circumstances would call for a return to coralia), until the evident transformation of whooping-cough into simple bronchitis. Hughes remarks: "Primary pneumonia is rare, but here, if ever, Teste's chelidonium would be of service." Frequent fits of violent, dry, hollow, or short exhausting cough, excited by severe tickling in the larynx, which brings tears to the eyes; heat and sensation of dust in the trachea, throat, and behind the sternum, not relieved by cough; generally without expectoration, but sometimes the exhausting morning cough causes expectoration from deep in the lungs; tightness in the neck and throat, and difficulty in breathing; stitches in the left clavicle and in the left mammary region. I have generally used the sixth dilution, as advised by Teste, but some cases needed the third decimal dilution.

Hyoscyamus is indicated when great fear is manifested at the appearance of each paroxysm, with jerkings and startings from sleep. The cough is dry, spasmodic and shattering, with frequent rapidly succeeding spells, excited by tickling as if from adherent mucus, at night without, in the day time with expectoration of saltish mucus, or of bright-red blood, mixed with coagula. Harry Thomas remarks that when the patient is lying down, the whoop is not loud. The cough is worse at night in a recumbent posture, after midnight, by cold air, by eating and drinking; vertigo as if intoxicated, the head rocks on this side and on that; the

eyes protrude; heat and redness of the face; ability to swallow liquids only a little at a time, with violent thirst; spasm of the chest, compelling to bear forwards; wheezing respiration; trembling and coldness of the hands and feet; convulsions.

I have good results from the dilutions 6th to 12th, but would expect hyoscyamus to succeed in almost any preparation.

Opium is sometimes given if a whooping-cough remedy, apparently well indicated, does not produce the desired results, and it is a priceless remedy in some of the dreaded cerebral complications. Kafka writes:—"We give opium 3rd, if the children, with visible symptoms of cerebral hyperæmia, and in consequence of pressure upon the brain, become entirely stupefied, or even soporous, and during the sopor, breathe snoringly, and with the lower jaw hanging down." Hughes remarks that when convulsions are attended with symptoms of cerebral congestion, the brain never properly recovering itself during the intervals between the paroxysms, opium should be given in alternation with the medicine for the spasm, but opium, especially if given *high*, is often the remedy for the spasm as well as for the cerebral congestion. The stupor is accompanied by hot perspiration, with anguish and irregular breathing; constipation is almost always present.

Kafka advises the 3rd, but I would suggest the 30th—singly and alone.

Hartmann advises *ledum palustre* for the purpose of rendering the cough loose and mild, but Kafka was the first to point out its use in one of the dangerous complications which make up the peril of this disease. He writes: "*Ledum palustre* 3rd, we apply under the same phenomena (congestion of the brain during and after the attack, followed by contraction of the extensors with pains in the contracted muscles), if children, after the attack, totter about as if intoxicated, moan and groan much during sleep, and even,

after the attack, the diaphragm contracts convulsively to such a degree, as to render the inspiration double and sobbing, similar to the expiration after severe crying.

Kafka, Laurie and other excellent writers seem to regard arnica merely as a remedy for the hæmorrhages which sometimes appear in the course of whooping-cough, and even Hernig writes: "Arnica is useful when there is considerable hæmorrhage from the nose and mouth, or the eyes are injected with blood, when blood is extravasated round the eyes, and they appear as if bruised, and also when each paroxysm of cough is followed by crying." Other writers—Hartmann, Pulte and others—dwell almost exclusively on the last of Hernig's indications, but there is a good deal of truth in Kafka's criticism: "Arnica is praised, if the attack of whooping cough sets in after coughing. But we know that most attacks of whooping-cough will as easily be provoked by crying, as by laughing, running, shouting, by smoke, cold drinking, etc., as principally by any agent which causes a constant irritation of the trachea, bronchi or larynx. The paroxysms of the arnica whooping-cough are excited by a creeping in the trachea, generally dry, often with expectoration of frothy blood mixed with coagula, or of badly tasting slime; the patient places his hands upon the chest to support it during the coughing fit; cough occasional during the day, but more frequent and severe in the evening, till midnight; worse from motion, in the warmth and after drinking. The left cheek is swollen and red, with heat in the head and coldness of the body; the child feels sore all over, as if bruised; bleeding from the nose." I have always used the dilutions from the 6th to the 12th decimal.

Lachesis is indicated by a hacking spasmodic cough, excited by tickling in the stomach and succeeded by a hoarse noise in the throat; *worse after every sleep*; during the day some watery mucus is dislodged with difficulty; disposition to deep inspiration; sensation as if there was something fluttering about the larynx; hoarseness even to aphonia;

emaciation and extreme depression ; with lassitude and drowsiness. Kafka writes : " Should veratrum not fulfill our expectations, we give lachesis, the effect of which—if the preparation is good—manifests itself amazingly quick, more so if there be present at the same time great weakness, frequent fainting, jerking of the limbs or convulsions." I have never given lachesis lower than the 12th centesimal, but the 30th acts very well indeed.

Baehr writes : " Arsenicum album is no real remedy for whooping-cough, but of great value if the organism has become very much enfeebled by the long duration of the disease and the violence of the paroxysm. The patients become sensible for some time previous to the approaching paroxysm, become exceedingly restless, seem tormented by anguish ; owing to their great prostration, stool and urine are passed involuntarily. Arsenicum deserves particular consideration, if the pulmonary tissue has become atrophied, or acute emphysema has set in."

The arsenicum cough is clear ringing, crowing or whistling, excited by burning tickling in the trachea and throat-pit, as if from vapors of sulphur ; at night without, in the daytime with expectoration of scanty, frothy mucus, or in lumps, sometimes mixed with florid blood, returning periodically with increasing violence ; expectoration of frothy mucus, often accompanied by suffocative spells ; before the paroxysm, the face pale and cold, with vomiting of food and drink, starting up in sleep as if from suffocation ; during the paroxysm the face is puffed and blue, burning in the throat, nausea, retching, sensation of bruised soreness in the abdomen, restlessness, anxiety and despair ; the paroxysm ends in sweat. There is great prostration, with waxy paleness and coldness of the skin ; intense thirst, drinking often but little at a time ; aggravation at night, particularly after midnight.

Kafka writes : " If during and after an attack the signs of *collapsus* are predominant, the children, who are generally

of a delicate build, feeble and sickly, after every attack are prostrated, anæmic and weak; if before it, we notice the greatest anguish and restlessness; if during the attack cold perspiration breaks out on the forehead and extremities, the children, after the paroxysm, which very seldom reaches that intensity of the other forms, have sunken cheeks and cold extremities, the pulse being at the same time accelerated and feeble, the thirst increased; if the children perspire much during sleep, which does not refresh, are very cross when they awake, inclined to cry; if the appetite is very little, while simultaneously the intestinal secretions are increased, if the muscular power is very much diminished; if, in consequence of the weakness, they desire mostly to be carried, while larger children drag themselves about, frequently lie down, and find no pleasure in their customary plays—under such circumstances we have in kali arsenic third (a dilution of Fowler's solution), a quick and sure remedy, which is not only able to lessen the attacks, but which also very beneficially affects the total complex of these phenomena. We generally give of this remedy from four to eight drops in half a pint of water, and order thereof one or two teaspoonfuls every two or four hours. This remedy is here, as in asthm. nerv., effectual in very high and low dilutions."

Kafka continues: "Under these symptoms, china, 3d, is likewise an excellent remedy, amending the general constitution. We like to give it principally if the symptoms of nervous erethismus, combined with those of adynamia, are prominent. Yet we must confess that its effect, in regard to the amelioration of the attacks, is to us very questionable; therefore, we have in this stage of the disease, in order to correspond to all its phases, made experiments with chinin, arsenic, third, which completely satisfied our expectations. Since this remedy, even in this trituration, tastes bitter, and children frequently refuse to take it, we suspend from five to ten grains of it in half a pint of water, and

order of this solution, well stirred before use, one or two teaspoonfuls every two hours."

Ruddock found kali bichromicum of great value when there is *much tough, gluey phlegm, which adheres to the throat and causes frequent vomiting*. The cough may be violent, choking and rattling, with difficult expectoration of viscid mucus which can be drawn out into long strings, or it may be short, hard and wheezing, and almost without expectoration. The cough is worse after eating, and deep inspiration, and it is often followed by vomiting; burning pain in the trachea and bronchi. I have, following the example of the English practitioners, always given this remedy *low*, say the 3d or 4th decimal triturations.

Kali carbonicum was recommended by Hering and Bœnninghausen, and found to be a specific in epidemic whooping-cough, characterized by a sacculated swelling on the upper eyelid, and it is a leading remedy where œdema complicates whooping-cough. Kafka writes: "Frequently it happens that the cyanosis, in consequence of the long-lasting spasm of the glottis, assumes a high degree, and that children after the attack swell œdematiously, now in the face, principally around the eyes and lips, then at the upper, then at the lower extremities. In such a case, if the œdema shows itself in the face, we give kali carb., 6th, in solution, from two to four hours; yet the application of these remedies is not as necessary, since the œdemata, if the attacks grow milder, mostly disappear spontaneously. Besides this, these remedies, according to our experience, have no decided effect on whooping-cough; for this reason, and in order not to lose time, it is more advisable, even if the œdema remains, to select another remedy more suitable for the attacks."

Calcareo carbonica is a leading remedy when whooping-cough occurs in teething children of scrofulous constitution, especially when convulsions threaten. The cough is short and spasmodic, in brief but often repeated paroxysms,

excited by tickling as if from down in the throat and trachea ; evening and night without, morning and day with copious mucus, or purulent, yellow or grayish, sometimes bloody sputa, of sour taste and offensive odor ; worse in damp, cold air, from getting wet, washing, bathing, from talking, after sleep ; in teething children cough comes always after eating, and they vomit their food.

Silicia is a most important remedy when whooping-cough occurs in a tuberculous patient, Bæhr writes : "Of particular importance, and involving a good deal of danger, is a combination of whooping-cough with tuberculosis, whether the latter was caused by the cough or existed previous to its occurrence. Naturally enough the paroxysm of cough irritates the diseased lungs in a most dangerous manner, and invests the cure with immense difficulties." This remedy would be of little use lower than the 30th, and the 200th would be better still.

Iodine is of almost equal importance with silicia in tuberculous cases, and should always be borne in mind when the patient is weak, sallow and emaciated, especially when this condition has been preceded by great nervousness. The spasmodic cough is excited by intolerable tickling in the larynx and suprasternal fossa ; mornings without, and evenings with frequently copious, tenacious, yellow, or bloody mucus expectoration ; worse by getting heated, walking, talking, going up stairs ; vomiting of food received at every meal ; canine hunger ; epigastric pains ; emaciation, but nevertheless a good appetite ; prostration ; swelling and induration of the glands ; dry, dirty skin.

EDITOR'S TABLE.

FOREIGN NOTES.—A personal letter from Dr. Apostoli of Paris to the Editor of recent date, gives the information that he, in company with quite a delegation from Europe, will attend the International Medical Congress, in company with Dr. Bantock (prominent ovariologist of the Samaritan Hospital, London), Dr.

Edis, (author of *Edis's Work on Diseases of Women*), Dr. Hewitt (who requires no introduction to our American readers), Dr. Kidd, of Dublin, and Dr. Imlach, of Liverpool. Drs. Martin of Berlin (the cervix amputator—his treatment for almost all troubles about the cervix), and Cordes, of Geneva, will also accompany the above.

Our readers who have been in Vienna and Prague, will be interested to learn of the following changes in the Hospital Staff of those places : Dr. Ehrendorfer, late assistant to Prof. Spaeth—the latter one of the most skillful operators, for the relief of that obstinate disorder known as vesico-vaginal fistula, we have ever had the pleasure of meeting—has been appointed to the chair of Obstetrics at Innsbruck (down in Tyrol). Prof. Ludwig Bandal has been assigned a lecture course at the University of Vienna. Prof. Bandal will be recognized as the late Professor of Obstetrics and Gynæcology at Prague, taking Prof. Briesky's place, who is now at Munich. Prof. Esmarch, that grand old teacher of surgery at Kiel, has been elevated to the rank of nobility of Prussia, his wife belonging to the royal house. Prof. Pawlink of Vienna is now occupying the chair of Obstetrics and Gynæcology at Prague. All of the above changes affect, more or less, the standing of all the late assistants of the various chairs in Vienna, many names now having been advanced to a full professorship in some other city.

In connection with our daily office practice, when employing Faradization, we have been in the habit of placing an electrode on the sacral region, made by Sarah E. Post, a Bellevue trained nurse, which is a curved plate constructed upon a chord of four and three-fourths inches, with arcs of 50° and 114° and a width of three and one-half inches. It can be applied to flat surfaces. It weighs about six ounces and is so constructed that it permits the electrode to be applied closely to any part. I find it preferable to the sponge or flat plates. With this electrode I employ a wire brush, made by Tieman & Co., under the direction of the same lady, which is attached to the other pole, to the hypogastric region. In the hands of my assistant we can give a complete and effective electro-massage to our patients. The movement of the hands of the assistant being those of a true massage. After a ten-minute treatment with the brush the patient always expresses her-

self greatly relieved. The brush is a modification of an ordinary wire brush.

For its adaptation a hole is bored through the wooden back, lined with conducting material, and fitted to the battery key. In use the insulated wire is grasped with the handle of the brush. If kept moving all shock may be avoided. It has been applied to the entire surface of the body, force enough being used to thoroughly redden the skin. It is especially agreeable to very fat people.

La Cronica Medico-Quirurgica reports, in its September issue, the first case of laparohysterectomy made in the Island of Cuba. The condition for which removal of the uterus became necessary was a pedunculated subperitoneal myofibroma complicated by an interstitial myofibroma. The operation was performed by Dr. Francisco Cabrera Saavedra, and its successful termination, in the restoration of the woman to health, reported to the Academy of Scientific Medicine of Havana on May 18, 1887.

A Laboratory of Bacteriology and Institute of Antirabic Vaccination has been established in Constantinople.

Dr. L. Rousse, of Fontenay, has devised an instrument upon the principle of the densimeter of Rousseau. He has designated it as a galacti-densimeter, or an instrument for ascertaining the specific gravity of milk. It has also the form of a volumeter, bearing upon its upper end a little receptacle which holds five cubic centimeters of milk. The instrument is placed in distilled water, and shows by an index a greater or less specific gravity, according to the depth to which it sinks. The estimation must be reduced upon a basis of a temperature of 15.5° C. (70° F.), and for this purpose a table is given with the instrument. Dr. Rousse has found that woman's milk of good quality varies from 1030 to 1036.

The society for the protection of infants, in Paris, announces a prize of five hundred francs (one hundred dollars) for the best thesis on "The Coryza of Children in the Early Years of Life." All theses must be transmitted, before November 1, 1888, to Dr. Blache, 4 Rue des Beux-Arts, Paris, France.

Professor Olshausen, of Halle, has been called to the chair of gynæcology at the University of Berlin, left vacant by the death of Schröder. At his first lecture, delivered the 5th of last May, he pronounced a most sympathetic eulogy on his predecessor.

Roumania is represented in the medical world by a new journal, the *Archives Roumaines de Médecine et Chirurgie*, which will be published monthly at the Alcan library. The manager, Dr. Assaky, professor of clinical surgery at the Faculty of Medicine of Bucharest, assumes the editorship.

In Russia it has been decided to establish, definitely, a course in medicine for women. The question was formerly one of giving to these courses the name of "Medical Faculty for Women," and of conferring upon the students a right to a diploma in medicine. This idea was abandoned for many reasons, and it has been resolved to limit the institution to simple courses of medicine for women, of which four ought to be devoted to theoretical studies and the fifth to clinical work in the hospitals.

After a long and honorable connection with the Philadelphia Homœopathic College, Dr. O. B. Gause has retired from the faculty and has removed to Aiken, S. C. Physicians sending patients to the South will be glad to know that Dr. Gause will continue to practice in his new locality.

COMMUNICATION.

DR. FUNKHOUSER'S CASE IN THE APRIL NUMBER.—This case is typical of a class that brings more discredit upon Homœopathy and Homœopathic practitioners than any thing else. And it is in the hope that some of them may be choked off that this criticism is written.

"Ulceration" to start with : what is "ulceration" ? A Gynæcologist of experience informs me that he never has seen it except in two cases and then the "ulcers" were specific ; there is no evidence that these were or that the disease was any thing more than follicular erosions.

Look at this ? "Guide to the practice of Homœopathy.

When you have a patient with gastric indigestion, constipation, dysmenorrhœa and 'ulceration' give puls. 1x and cimic. 1x each twice a day ; nux vom. 2x three times a day ; hot douche night and morning ; apply the Hell-stone of the Germans once a day to the 'ulcers' : and lastly, if there is, as a result of all the disturbances, relaxation of the tissues, put in a McIntosh pessary."

You don't like that way? Why Dr. Funkhouser says that we had better use any thing (he might almost have said every thing) for the lasting benefit of our patient "as well as for our own aggrandizement, that will secure the desired result." Very good as far as that patient is concerned. From whom did Dr. F. learn the properties of the drugs he used? Was it from men who used four remedies in rotation, or from those who proved and gave single remedies? Who is the wiser for this case? No one! Who is the better physician? No one! Who, like the cock that crows from his own dunghill, has aggrandized himself? Dr. Funkhouser! The patient got well! apparently she did: what cured her?

"We Homœopaths are too tender-footed in regard to any thing savoring of irregularity." "We Homœopaths" is rich! And those tender feet! The Doctor's feet must be tough indeed to enable him to travel over such a road as he marks out. If his feet were tender from traveling the rugged way laid out by Hahnemann and his disciples, instead of rushing in with such a case as his, he would carefully tread in the footprints of men whose lives have been spent in developing the truths which, if applied by Dr. F. as Homœopaths indeed apply them, would aggrandize him above all his present sordid ambitions. Our duty as physicians is to keep our patients from going into the hands of others by curing them, which can only be done under the law of similars. Our duty to the profession and the journals is to keep still until we can teach something.

If we are going to be Homœopaths, let us treat women suffering from diseases peculiar to their sex, as we treat them when they suffer from other diseases, viz: under the law of similars, with the single remedy and the smallest dose necessary to cure; if the 6th will do it, we commit a sin in giving the 3rd: if the 30th is sufficient, why poison them with the 6th? if 2x is necessary,

give it ; but don't play Allopathic wolf in the wool of a Homœopathic sheep.

CHAS. B. GILBERT, M. D.,
Washington, D. C.

TRANSLATIONS.

DYSENTERY AND SUMMER DIARRHŒA. By Dr. L. Unger, Vienna. Translated by S. Lilienthal, M. D. *Wiener Med. Presse*, 28, 1887.—The diagnosis of summer diarrhœa includes different pathological processes, from a slight dyspepsia to cholera infantum and dysentery and in relation to their etiology a differential diagnosis is of the utmost importance. Hippus reports of nearly three thousand cases of dysentery observed during five years in the Children's Hospital, Moscow, and the patients were nearly all neglected waifs of poor parents, fifty-five per cent. were below ten years ; on the beginning of summer nearly two-thirds of dysentery were observed among the tender plants ; whereas, during August and September the older children were more affected. In meteorological relation he discovered: First. The temperature of the air is of great influence on the course of a dysentery, especially injurious are high degrees of heat, often followed by a sudden cooling of the air ; in both cases the morbidity of dysentery increases. Second. Dysentery does not cease with the summer heat, but continues into autumn, and often meteorological relations prevail favorable for its continuance. Third. Moisture in the air may originate dysentery, and considerable sudden increase of moisture in hot weather produces a higher morbidity. Fourth. Oscillations in the temperature of the air and in moisture are more noxious in the first part of the summer than in the latter part. Fifth and Sixth. Cloudiness, wind, and the quantity of ozone in the atmosphere, are in their higher degrees unfavorable for the origin of dysentery, but barometrical pressure, rain, wet soil, and thunder storms, have little influence on the course of dysenteric morbidity.

These views do not fully agree with the views of other authorities, who consider the heat of the summer as the chief cause of these diseases, inasmuch as the heat relaxes the human organism

and produces fermentation and putrefaction in the surroundings as well as in the ingesta and thus indirectly injures the process of digestion. That dysentery, under the influence of summer heat, appears simultaneously with cases of diarrhœa, and that little babes often succumb to it, and again that factors inhibiting putrefaction, as cool weather, wind, ozone, also inhibit the multiplication of cases; are facts agreed upon by all physicians. Heat *per se* has no absolute sovereignty in the etiology of dysentery, for just in late summer or fall we observe frequently the greatest morbidity. There must be another important factor and that is *contagiosity*.

Our autochthonous arising epidemics of dysentery differ in nothing from those of the tropics. In both cases we deal with a miasmatic contagious disease of infection where the contagion does not travel from person to person, but is carried by the excrement of the dysenteric patient. The autochthonous origin of epidemics always develops itself from sporadic cases. At first their contagiousity is hardly noticeable, but gradually by the accumulation of excrementitious matter and its 'putrefaction under the influence of moisture and heat the contagiousity increases, and the epidemic is established. Often we see that the same disease, which on the beginning of summer was diagnosed as colitis or enteritis follicularis, becomes in the fall more frequent and intensive as a dysentery. Henoch candidly acknowledges that it often remains doubtful in children under two years whether we have to deal with a genuine infectious dysentery or with a not infectious acute catarrh of the colon. Mucus and small quantities of blood may appear in the discharges of every catarrhal diarrhœa and even tenesmus is not rare. Only when the discharges become more frequent and only some bloody mucus, or small stools of much mucus, and blood mixed with some fecal matter, is discharged, we may diagnose it as a case of dysentery, but still there is not a genuine dysentery, for anatomically and clinically it is after all only a colitis, whose infectious nature is caused by the accumulation of putrefying fecal matter at certain times, especially during August and September.

The heat of summer acts either directly (by its immediate action) on the human organism or indirectly by its action on the

surrounding ingesta. Directly it acts relaxing on the nervous system and muscles, hence retardation of intestinal peristalsis and decomposition of the intestinal contents, which again causes a strong continuous irritation to the mucous membrane, and this becomes of importance in small children where the colon is relatively of great length. As during every intestinal contraction the veins become compressed and thus inhibit the return of blood, catarrh easily arises, and with it often reflex spasm of sphincters; tenesmus. The indirect influence of summer heat is caused by the processes of fermentation and putrefaction all around us. Other meteorological factors—moisture of the air, its stagnation, small quantity of ozone and much sunlight—support energetically this influence. Food and drink are thus easily exposed to be spoiled and may cause diarrhœa. The exhalation of putrefying matter in our cities is another noxa for the intestines.

Another important cause is sudden cooling of the air and a rapid rise of moisture. *Catching cold* is of as much importance in summer and not enough considered in relation to small children, whose apparatus for the regulation of heat as yet acts imperfectly, and whose bodily surface in relation to its weight is rather large. Babes and children have only little resisting power, become easily exhausted, and thus the frequency of intestinal affections are easily explained.

DEAR DOCTOR.—We translated this article of Hippus and Unger, because it contains a hint too much neglected in our daily rounds, and that hint is the contagiosity produced by soiled diapers, infecting the air, especially in tenement houses in the overcrowded parts of our cities. These poor waifs suffer for the ignorance of their poor mothers, and it is the duty of the humane physician not only to prescribe drugs, but to look to the hygienic surroundings of the patient, and instruct the family on the sacred obligations to preserve the health of the little ones intrusted to their paternal care. Let the mothers understand that it is easier to keep them well than to cure them, and by careful diet, by cleanliness even in minute things; by plenty of suitable fresh air, guarding at the same time against catching cold, children may pass that dreaded second summer without falling a prey to these abdominal and nervous disorders. Let us physicians do our duty,

let us consider ourselves guardians of health and not only mere healers, and a great advance will thus be made in medical science.

S. L.

GELOSINE AS A CUTANEOUS ELECTRODE IN THE APPLICATIONS OF HIGH ELECTRIC INTENSITIES.* By DR. P. MÉNIÈRE, Paris, France.—In a great number of uterine affections, and particularly in fibromata, in the case of menorrhagias and metrorrhagias, in certain forms of endometritis, when the question is to practice electrolytic acupuncture, following the method I have praised in the columns of this journal for the treatment of chronic parenchymatous metritis, the use of currents of high intensity imposes itself more and more in the practice of gynecologists desirous of obtaining appreciable results.

It is to the work of Apostoli, to the success which he obtained in this direction, that we owe this progress; and taking into account all the exaggerations which the enthusiasm of an innovator can not avoid, it is incontestable, and we affirm it on the basis of our own experience, that the high doses in which electricity has been administered by Apostoli really constitute a method, not only new, but of much superior efficacy to all the standard means of gynecological therapeutics. But to make bearable more than thirty or forty milliamperes and render the pole indifferent, of which the only use is to close the electric circuit, it is necessary to resort to certain contrivances.

All those who have done a little electrotherapy know perfectly well that the electrode in contact with the cervix, or with the uterine mucous membrane, does not provoke any appreciable pain in that organ, except in cases of inflammatory or neuralgic affections, no matter what the intensity of the current, while the electrode, which completes the circuit, and which is in contact with the skin of the hypogastrium, or of the thigh, produces a keen pain and burn, indeed, sometimes even an eschar, so much the more serious as the intensity of the current is increased.

In vain they have sought to avoid this inconvenience by covering the metallic plate which serves for the cutaneous electrode with

* De la Gélosine comme électrode cutané dans les applications de hautes intensités électrique, par le Dr. P. Ménière.—*Gazette de Gynécologie*.

amadou and leather ; that they have given it larger dimensions ; that they have substituted large leathers or wet towels, presenting a large surface of wet paper, of metallic sheets in gold or silver, etc. ; all these means, which appear to settle the difficulty because they agree with that which theory indicates to us, have been of no good in practice, and it has become necessary to find better.

In a communication made to the *Académie de Médecine* (Oct. 10, 1882), Apostoli has praised clay (modeler's clay, loam, sculptor's clay), which, among other advantages, which it would take too long to enlarge upon at this time, presents that of applying itself in as exact a shape as possible to the skin, and of adhering to it at all points if it is of a convenient consistency, of conducting the current very well when it has the necessary degree of humidity, of not getting heated, of not burning the skin, and above all of rendering painless the highest intensities actually employed. I acknowledge then that the electrode of clay presents great advantages, since it realizes an incontestable progress which it was necessary to reach, but it has equal inconveniences on which I shall dwell intentionally.

First, it is dirty, and most of our patients have complained, and justly, that their skin, their linen, etc., was blackened, soiled after each application, and this is inevitable. If it does not soil, then it is because the surface of the cake of clay commences to dry, and then it conducts much less of the electric current, and does not mold itself as exactly to the skin.

On the other hand, certain patients complain of the excessive weight of the electrode, which is 1,000 to 1,500 grammes on an average. In short, the preparation, the preservation, the remodeling of the cake of clay, involves so much difficulty and loss of time that it is not satisfactory. We have, then, sought a body which could offer the advantages of clay without its inconveniences, and it is on gelosine that we have settled, waiting to find better still, which is not impossible.

Gelosine is the mucilaginous principle which R. Guérin, chemist in Paris, has extracted recently from the *geledium corneum*, a sea-weed from Japan which is found abundantly at Singapore.*

* *Bulletin de thérapeutique*, 15 juillet 1886, p. 31 ; de la Gélosine, par R. Guérin, pharmacien-chimiste à Paris.

This curious substance, of which the therapeutic applications are going to become very numerous in proportion as our confrères learn to know it, dissolves, or rather swells in an excessive manner in boiling water, of which it can solidify just five hundred and fifty times its volume.

By cooling we obtain a beautiful, transparent jelly, able to take all possible forms, little alterable, always damp on the surface, and of which we can vary the consistency according to the end we propose. This jelly is a good enough conductor of the current not to oppose a superior resistance to that of the human body. Cast in *plaques* from two to three centimetres thick, it has a flexibility which permits it to apply itself very exactly to the skin.

It is, moreover, a clean substance, a surface always damp but not wet, and the weight of an electrode cake, sufficient to cover all the hypogastric region, does not reach half the weight of an electrode of clay of the same dimensions. To all these qualities it is necessary to add, that which the clay possesses, to remain indifferent, that is to say not to become decomposed under the influence of an intense electric current, not to become heated, and, in consequence, not to occasion any pain nor any eschar of the cutaneous surface with which it has been in contact.

From all these points of view we do not, then, hesitate to recommend the electrodes of gelosine to the attention of electrologists. We have used them regularly for several weeks, and we have renounced forever the clay. But this electrode ought to be prepared and fashioned with certain precautions, and, to be complete, I am going to show the mode of preparation at which I have arrived, after a period of groping, difficult enough, but very instructive from an electrologic point of view.

M. R. Guérin has been so extremely obliging as to put at our disposal the gelosine which he prepares, and it is with this product that we have made all our experiments.

Here is the formula at which we have arrived :

Gelosine,	18 grm.
Glycerine (neutral) .	100 grm.
Water	500 grm.

Heat the mixture in a glass or porcelain capsule, and stir with a spatula of the same material till the dissolution of the gelosine

is complete. As soon as the liquid begins to boil pass it through a coarse muslin and let it strain. This last operation ought to be done in a porcelain vessel, oval shape is preferable, or even on a very smooth oil-cloth, or a glass plate with a brim of card-board. In every case these different utensils ought to be arranged or chosen of such form that the electrode would be about twenty-five centimetres by fifteen.

Half the boiling liquid is then strained ; leave it to cool five or six minutes, and lay on its surface a sheet of tarlatan, or better, of muslin, intended to give to the electrode a solidity which it would not have without that. We finish then the straining of the other half of the liquid over this and leave it to cool. At the end of twenty or thirty minutes, and more rapidly if the mold is placed in the air or in a vessel filled with cold water, the mass is solidified and can be used immediately. I shall add that it is very important to put in contact with the skin of the patients the side of the electrode corresponding to the smooth surface of the mold. In not conforming to this indication one is apt, if some bubble of air has burst at the surface opposite to the electrode, or if it is a little undulating at certain points, or if, in short, some lump renders the surface unequal, one is apt, I say, to produce little eschars at this point. This accident happens with ordinary electrodes, with the chamois, and even with the clay. It is not produced when the surface of the cake of gelosine is absolutely smooth as porcelain. Of course the electrode will be put in relation with the battery by medium of the conducting cords and of an ordinary plate electrode, and when not in use will be wrapped in oil-silk in order to avoid its desiccation.

BOOK REVIEWS.

A PRACTICAL TREATISE ON DISEASES OF THE EYE. By DR. EDWARD MEYER. Translated with the assistance of the author from the Third French Edition, with additions as contained in the Fourth German Edition, by FREELAND FURGUS, M. B. P. Blakiston, Son & Co., Philadelphia, 1887.

The first appearance of this book in the English language is a cause for the presentation of congratulations to its distinguished

author ; for, having been translated from the French into six other languages, in its English dress it is worthy of high rank among our standard text-books on Ophthalmology. In the very beginning one is at once interested in finding impressed upon the student the necessity for *Method* in examinations of the eye. So many text-books take it for granted that the reader has become an expert, that it is with pleasure we find a work giving a foundation upon which to rear the superstructure of a diagnosis.

The use of the ophthalmoscope is certainly of importance to obstetricians for diagnostic purposes in the albuminuria of pregnancy, if nowhere else, and much might be added to the literature of kidney troubles, were those who make a specialty of obstetrics able to make a careful examination of the fundus oculi. This work of Meyer's presents all the details necessary for the examination of the eye by the ophthalmoscope in so plain a manner that one finds here all that may be required.

It is unnecessary to allude to all the features of the work, suffice it to say that, we have found it written in a style corresponding with the introductory chapter, that is methodical, and, following a method, the text is easily retained by the student.

THE PRINCIPLES OF ANTISEPTIC METHODS APPLIED TO OBSTETRIC PRACTICE, by DR. PAUL BAR, Paris. Translated by HENRY D. FRY, M. D., P. Blakiston, Son & Co. Philadelphia. 1012 Walnut St. 174 pp. Cost \$1.75.

The widespread interest the profession has taken in antiseptic methods in obstetrical practice makes of this small work a welcome addition to Messrs. Blakiston's valuable library of medical books for 1887.

The subject as presented by the author furnishes a careful study of antisepsis in general ; considering not only the genesis of the disease in its relation to the puerperium, but also the application of the germ theory ; fermentation ; putrefaction ; infectious diseases caused by germs ; the channels by which germs are introduced into the system ; the conditions which favor or resist their multiplication ; putrid infection, the pyogenic micrococcus ; the septic vibrio ; mixed infection ; objections to the germ theory ; puerperal infection.

Pasteur's investigations upon fermentation and more recently upon putrefaction have led the profession into many extravagant theories that can not bear the close scrutiny of a scientific examination. Many converts to his theories have been carried away by their enthusiasm and have established false doctrines that will require time and patient labor to refute. The old quotation taken from the ancient doctrine that "Disease is in us, it proceeds from us, it is created by us" is met by the opposite theory

that "Disease comes from without, it is always of parasitic origin." Thus the question is presented and the logic advanced by the author is indeed a masterly effort and his language does much to clear up the mystification of a subject so little understood and appreciated by the medical profession.

The antiseptic agents employed are simply those well known to the average practitioner and which have their curative effect in the destruction of germs by their introduction within the organism of patients.

We heartily indorse the book as a valuable as well as a readable work on antiseptis.

ON THE PATHOLOGY AND TREATMENT OF GONORRHŒA AND SPERMATORRHŒA. By J. L. MILTON, Senior Surgeon to St. John's Hospital for Diseases of the Skin, London. Octavo, 484 pages. Illustrated. New York: William Wood & Company.

As a special work we regard this treatise by Milton as a valuable addition to the history of gonorrhœa and to the pathology of gonorrhœa, gleet, spermatorrhœa and impotence. It will be especially valuable, to the progressive medical man, to study well the *complications* of gonorrhœa. In no other book have we seen it more forcibly impressed that gonorrhœa does not alone expend its force upon the urethral mucous membrane.

That it bears relation to the general system cannot be doubted after reading the careful exposition of the manner in which gonorrhœa implicates the fibrous and serous tissues.

In this relation it is certainly fitting to introduce gonorrhœal affections of the eye, but more care should have been given to precision in nomenclature. To use the term *ophthalmia* to designate an affection of the conjunctiva arising from infection with irritating urethral pus (properly conjunctivitis gonorrhœica) is certainly most indefinite and the same may be said of the antiquated term "*aquo-capsulitis*," which according to the given description might be either a Descemetitis or a serous iritis.

The treatment of gonorrhœa in woman more particularly attracts our attention and we find this portion of the subject has received careful attention. The author has seen five cases of acute ovaritis ensuing from an attack of gonorrhœa. While we cannot entirely agree with Mr. Milton in his treatment of these affections, we must in conclusion give him credit for a careful study of the drugs employed in his practice.

BOOKS AND PAMPHLETS RECEIVED.

INTUBATION OF LARYNX. Papers read before the New York Academy of Medicine, in the stated meeting of June 2, 1887,

by A. Jacobi, Joseph O'Dwyer, Francis Huber, Dillon Brown, W. P. Northrup, I. H. Hance and A. Caillé. Reprinted from *The Medical Record*, June 18, 25, and July 23, 1887.

REPORT OF THE CALCUTTA HOMŒOPATHIC CHARITABLE DISPENSARY for the year 1886-87. No. III.

THE PATHOLOGY AND PHYSIOLOGY OF DIABETES. By Prosper Bender, M.D., Boston, Mass.

EIGHTEEN CASES OF EXTERNAL PERINEAL URETHROTOMY. By H. O. Walker, M.D. Reprint from the *Medical and Surgical Reporter*, June 18, 1887.

TREATMENT OF ANAL FISSURES AND HEMORRHOIDS BY GRADUAL DILATATION. By H. O. Walker, M.D. Reprint from the Transactions of the Michigan State Medical Society.

SOCIETY PROCEEDINGS.

INTERNATIONAL MEDICAL CONGRESS: NINTH SESSION:—SECTION IN GYNÆCOLOGY.—Monday, September 5th. First day.—The President omitted the formal address, and reserved the privilege of a more scientific contribution at a later date. He welcomed the foreign guests in the name of the profession of the entire country. Dr. Nathan Bozeman, of New York, read a paper, entitled

ARTIFICIAL AND COMBINED DRAINAGE OF THE BLADDER, KIDNEYS, AND UTERUS THROUGH THE VAGINA, WITH AND WITHOUT GRADUATED PRESSURE.

In this paper the author described an instrument which he had devised recently. This draws the uterine away from the mucous membrane, and in the most perfect manner. He has also been able to combine in the same instrument drainage with the dilatation of the cicatricial tissue of the vagina. The form of the instruments which concerns us here is intended for drainage alone, and I have called them intra-vaginal and vulvo-vaginal drainage supports. The intra-vaginal instrument is applicable in most cases to all positions of the body. The vulvo-vaginal form is suited to the recumbent position, and to cases where the perineum is lacerated. These can be introduced and removed by the patient when necessary. They are small and simple, free from angles and sharp bodies, are readily kept clean, and excite no discomfort or irritation of the vagina. They do not press on the rectum or vagina, nor do they interfere with locomotion.

The author closed his paper with the following conclusions :

First. The importance of completion of the operation for fistula has not been duly appreciated. This forms, in many cases, the principal difficulty in the successful performance of the operation for the closure of the fistular opening. In other cases, when the fistula is cured, but the complications left without treatment, they lead sooner or later to the death or suffering of the patient. The greatest care should therefore be taken to discover and remove them.

Second. Kolpoplexis, occlusion of the os uteri, and incision of the cervix in the bladder or rectum, are unjustifiable operations. They destroy the functions of the generative organs, lead to cystitis, then form venereal and vesicular calculi, pyelitis, and other diseases. Moreover, they are unnecessary. By means of the preparatory treatment of the complication by the aid of my button-suture and my dilating speculum, I have been able to overcome all the difficulties which have been described as indications for operation.

Third. The association of combined drainage in the dilatation of the vagina is a great improvement. The inconvenience and evil effects of incontinence of urine are thereby lessened, and the duration of the treatment shortened by the more rapid healing of the incisions and the formation of less cicatricial material in the reparative process.

Fourth. We now propose a means of palliating the suffering due to incontinence of urine in a small proportion of cases of fistula which are incurable by this method—even the dangerous one of kolpoplexis. I believe that some form of drainage may be instituted in every case, and the patient may be thus restored to enjoy life and the performance of its duties.

Fifth. The possession of a system of combined drainage will widen the scope of the operation of kolpo-cystotomy, done for cystitis, by removing the evils of incontinence of urine, now the chief objection to its performance.

Sixth. Finally, I think the operation which I call kolpo-urethro-cystotomy, followed by the exploration and treatment of the disease of the ureters and pelvis of the kidney, has a brilliant future before it. In the treatment of pyelitis, renal calculi, and obstruction of the ureters, it will restrict within narrow limits the operation of nephrotomy and nephrectomy. Dr. Horatio R. Bigelow, Washington, D. C., read a paper on

CONSERVATIVE GYNÆCOLOGY.

The paper was divided into the following heads :

First. Plan and purpose of this communication.

Second. The conservation of energy in its relation to conservative medicine.

Third. What is meant by conservative gynæcology?

Fourth. General medicine and its relation to specialism.

Fifth. The tendency to operative measures a dangerous one. Experience gained at a great cost of life. Operations often performed unnecessarily.

Sixth. Conservatism as applied to the treatment of uterine tumors. Recent results from the use of ergot and from the electric current. Exceptionally only do myomata call for laparotomies. The constitutional treatment.

Seventh. Conservatism applied to tubal diseases and inflammations of the ovary. The psychic element. The subjective and objective symptoms. Rest treatment, electricity, Swedish movement, and bathing.

Eighth. The relation of gynæcology to the general environment of the patient. Minor disorders magnified into undue prominence by social factors in the every-day life of women. The treatment of such cases.

Ninth. A consideration of oöphorectomy for hysteria, nervousness, and kindred disorders. Seldom warranted.

Tenth. The restriction of abdominal surgery to men competent to practice it.

Dr. J. E. Burten, LL.D., of Liverpool, England, read a paper on the subject

WHEN SHALL WE OPERATE IN TUBAL PREGNANCY?

The author considered these operations dangerous to life, more so, perhaps, than ovariectomies, while the diseases for which they are recommended and performed are, as a rule, not so. The operation is by no means a striking success therapeutically; many of the cases operated on are no better for it, some are even worse, while in good cases it takes at least twelve months for the patient to completely recover from its effects. We hear of "brilliant" cases that have taken two and three years before the "brilliant" results became manifest. It may be fairly assumed most of these would have recovered in that length of time without operation. When the results are the best possible the woman is mutilated for life, an offence against conservative surgery as well as the first canon of medicine, *non nocere*. The mutilation entailed by the operation is particularly offensive to the sentiments of all civilized nations, and reduces a woman to the position of a female eunuch. Her loss and degradation (?) will certainly be remembered when the recollection of her sufferings has faded. The objections to the operation being so grave, it ought to be performed only in justifiable cases—after (1) prolonged treatment by less heroic and radical measures; (2) consultation with colleagues; (3) full explanation of the nature of the operation and its results to the

patient herself and her nearest friend. As regards the operation itself it is justifiable in :

First. Rapidly growing or bleeding myomata after other treatment, patiently carried out, has failed.

Second. Pyosalpinx, if life is threatened by repeated attacks of peritonitis.

Third. Chronic ovaritis (especially inflammation of the albueginea when Graafian vesicles burst through), when the pain is fixed and constant, and months have been spent in unavailing treatment.

Fourth. Parametritis, which, though it may not be dangerous to life at the time, may render the patient a permanent invalid.

Fifth. Cystic degeneration of the ovaries, under the same condition as to pain as No. 4.

Sixth. Neuroses distinctly of ovarian origin that have withstood years of treatment.

The operation is not justifiable in :

First. Myomata, except as noted.

Second. Pyosalpinx, if the disease has become quiescent, if pain and fever have subsided and the pus has become inspissated.

Third. Hydrosalpinx at any time, unless an associated perimetritis demand removal of the parts. A less radical operation will usually suffice.

Fourth. Perimetritis, unless the disease promises to render the patient a permanent invalid.

Fifth. Ovaritis, except under the conditions noted.

Sixth. Cystic degeneration of ovaries, except under conditions noted.

Seventh. Hæmatocele and Hæmatosalpinx under any conditions. Laparotomy and drainage may be called for, but removal of the organs, never. The same applies to ectopic gestation.

SECTION IN OBSTETRICS.—Monday, September 5th. First day.—A paper was read by J. Braxton Hicks, M. D., London, Eng.

ON CONTRACTIONS OF THE UTERUS THROUGHOUT PREGNANCY, AND THEIR VALUE IN THE DIAGNOSIS OF PREGNANCY, BOTH NORMAL AND COMPLICATED.

Fifteen years ago the author had first directed attention to the fact that the uterus contracted throughout pregnancy at intervals of from five to twenty minutes ; since then he had added much to his previous knowledge.

Before the fourth month bimanual palpation was necessary, later external examination was sufficient for its detection. The pregnant uterus was very soft, and offered no appreciable resist-

ance to palpation except during contraction. In a young girl suspected of pregnancy abdominal palpation was often all-sufficient, though internal examination might be necessary. It was of great advantage to obtain decisive proof before making any allusion to pregnancy. A soft condition of the uterus, with a localized lump, often pointed toward the death of the foetus or to ectopic gestation. The uterus might contract about fibroids. A knowledge of the contractions often rendered easy a diagnosis otherwise difficult, as in ovarian tumor, ovarian tumor and pregnancy, ectopic gestation, and normal gestation, twin pregnancy, and hydramnios (palpation and the stethoscope as aids). With a dead foetus the walls might be rigidly contracted. We should always look for corroborative signs.

Several cases were then cited in which the diagnosis was rendered certain only by this sign. The conclusions were :

First. That the uterus contracted at intervals of from five to twenty minutes during the whole of pregnancy, remaining contracted for from three to five minutes.

Second. The uterus is firm when contracted, and the foetus cannot be distinctly felt, though when the uterus is soft the foetus is easily mapped out.

Third. By noticing the contractions we are often enabled to diagnose normal pregnancy from other conditions.

Fourth. The contractions have the physiological use of emptying the uterine veins of the carbonized blood.

Fifth. The carbonized blood probably excites the contractions. Duncan C. MacCullum, M. D., M.R.C.S. Eng., of Montreal, Canada, read a paper on

VICARIOUS MENSTRUATION.

After a *résumé* of the literature of the subject and the diverse opinions of modern authorities, the reader cited four cases :

First. Mrs. W——, aged thirty-eight ; six children. Never nursed. Good health. Two months after birth of child had molimina and vomited blood. Treated by rest, ice, and gallic acid. No unpleasant after-effects and no further hæmorrhage for four weeks, when she again had molimina, followed by hæmatemesis. At next period the menses reappeared and have been normal since. Continued good health.

Second. Healthy woman ; single. On the first day of a menstrual period was exposed to cold, and menses stopped ; next day vomited blood ; no vaginal discharge ; regular since and healthy.

Third. Patient, aged thirty-three ; healthy. First menstruation at fourteen years of age. Soon after had scarlatina, followed by amenorrhœa until eighteen. At twenty-three menstruation be-

came very scanty and was accompanied by epistaxis for six periods, when it became regular again. Recently has again become scant and is accompanied by the epistaxis as before.

Fourth. Healthy woman. Pregnant three months. Six weeks before had received a severe fright. Had a profuse hæmoptysis on two successive mornings, and three days later aborted. Four weeks later molimina and hæmoptysis, but since normal menstruation. Chest perfectly sound; good health. In this case the ovum was killed six weeks before ovulation became established, and obstruction being offered to the usual flow, hæmorrhage took place from the weakest point.

To constitute vicarious menstruation there must be (*a*) absence of menstrual blood-flow, (*b*) blood from some other organ than the uterus, and (*c*) no other assignable cause for the hæmorrhage than the increased premenstrual blood-tension. A hæmorrhage under these conditions is truly supplementary and clearly vicarious.

Prof. T. Lazarewitch, M. D., of St. Petersburg, Russia, presented

THE MECHANISM OF LABOR AND THE NORMAL FORCEPS.

After calling attention to the factors concerned in the mechanism of labor, and the necessity of an accurate knowledge of the mechanics of the process, he described a forceps which he had devised, having straight parallel blades, and locking with a simple tenon and screw.

His conclusions were :

First. That forceps be considered as a continuation of the hand as feelers.

Second. That the less the dimensions of the blades the better they could be guided.

Third. That detrimental action increases with the size of the blades.

Fourth. Convex margins should not be so thin as to cut, or so thick as to obstruct.

Fifth. That the instrument should lock easily, but allow slight longitudinal rotation of the blades.

Sixth. Blades should be parallel.

Seventh. Handles designed for convenience in guiding and the avoidance of injurious pressure.

Eighth. Should be of smooth metal, so as to be easily made aseptic.

Ninth. That the pelvic curve was injudicious, detrimental and difficult to employ.

Tenth. That his parallel normal forceps filled all these conditions.

SECTION IN DISEASES OF CHILDREN.—Monday, September 5th.
First day.—The first paper read was by JULES Simon, of Paris, who called attention to

A FORM OF CEREBRAL IRRITATION IN CHILDREN,

independent of organic lesion, and not the result of heredity or syphilis, but due to the deplorable tuition of young infants, even those at the breast, who are, in many cases, constantly harassed by the nurse with loud singing and sudden lights, and are liable to be excited by tea, coffee, or spirits, either directly or through the milk of the nurse. Add to these causes the feverish excitement which spreads around the cradle of the infant in modern society, and the result is a condition of cerebral irritation in which the child is unduly agitated by the most trivial causes. Sleep is light and frequently interrupted; exaggerated reflexes produce vomiting, subsultus and convulsions. The signs of precocity become more painfully evident when the child reaches the age of two or three years. He is in constant motion. The eye is restless and the expression vacant. The mind is alert, but incapable of application.

The cerebral irritation thus manifested may appear in the first months of life or it may gradually unfold itself at a later period. It terminates toward the age of five years, either by cure or by cerebral sclerosis, epilepsy, or meningitis.

It is the duty of the physician to secure a strict hygiene, with special view to prevent nervous excitement caused by unusual noises, or sights, or stimulating food and ill-advised friendly and social attentions. The open air and residence at the sea shore or in the country are desirable, and medication, when required, should be by the bromides. The brief communication of M. de Saint-Germain was as follows:

"Not being able to attend the Congress, I send a note from my surgical experience. What I bring is not a stone for the edifice, not even a pebble, only a grain of sand. But each must do the best he can. Please accept the will for the deed.

"He who invents a surgical operation receives great credit. Recognition, at least, should be given him who substitutes for two operations two simple procedures, less dangerous, quite as effective, and more easy to perform. I propose ignipuncture of the tonsils and preputial dilatation in place of tonsillotomy and circumcision.

"Ignipuncture of the tonsils. Tonsillotomy is not free from the possibility of fatal accidents. To mention uncontrollable hæmorrhage and invasion of the wound by diphtheria is to make it clear that the operation is not so harmless as has been supposed.

"Krishaber tried the thermo-cautery, but his application was so superficial that treatment was indefinitely prolonged.

"I operate with the aid of a modified Smith's gag, thrusting the thermo-cautery into the tonsil to the depth of three-eighths of an inch. Two to four applications, at weekly intervals, reduces the tonsil to a shriveled and insignificant stump

"As to preputial dilatation, it may well take the place of circumcision, which is sometimes followed by serious hæmorrhage, diphtheritic invasion of the wound, or partial gangrene.

"I reserve circumcision for those cases alone (about one in three hundred) in which dilatation is impracticable. I use a two-bladed dilator instead of the three blades of Nélaton, introducing it and slowly expanding the orifice. The operation is finished by separating the adhesions with a grooved director and is followed by daily massage, in which the glans is alternately exposed and covered.

"With both of these simple procedures I have always secured excellent and durable results, and have met with no untoward complications. In view of the great frequency of these two classes of cases, am I not right in presenting these simple and effective procedures as a surgical advance?"

Dr. Lewis A. Sayre, of New York, then read a paper on

THE DELETERIOUS RESULTS OF NARROW PREPUCE AND PREPUTIAL ADHESIONS.

His first paper on this subject was published in the "Transactions of the American Medical Association." He was the first to draw the attention of the public to this important subject. It is now generally admitted that paralysis, and various other nervous symptoms, including a want of co-ordinating power, are in some cases induced by the pressure of the prepuce on the glans. The remedy is removal of the constriction and of the retained and concrete smegma, and such an arrangement of the parts that the prepuce shall glide *easily* to and fro over the glans, without restriction, permitting cleanliness, and thus removing one great source of danger.

For this proper arrangement of the prepuce it is necessary in some cases to perform circumcision, or an actual removal of a small portion of the prepuce, and sometimes to dissect it from actual adhesion, which is a very different thing from ordinary normal agglutination. But there is no occasion for removing any tissue, unless there is great redundancy with constriction. And in the great majority of cases the object sought can be easily accomplished by pushing a grooved director as far back as possible, and then dividing with the curved bistoury enough tissue to allow of tearing back the prepuce and uncovering the glans. The

next step is to make a slight nick with the scissors, or bistoury, through the thickened fold of the edge of the frænum. Having done this, it is easy with the thumbs and forefingers to tear down the frænum and other adhesions, expose the glans, and remove from the sulcus behind the corona the hardened smegna, sometimes containing chalky concretions. In this procedure there is little loss of blood, and no loss of tissue whatever. A stitch on either side of the incision, between the skin and the mucous membrane, may or may not be required. Thus the glans is left partially covered, and it may, as well, be freely and easily uncovered. Having been responsible for bringing the subject before the profession, the writer wished to raise his voice against the mutilation and disfigurement of the organ, which is often seen, which by too free removal of the prepuce leaves the glans entirely unprotected, as well as against the indiscriminate performance of the operation in cases where it can be of no avail.

The object of the paper was to harmonize two views—that of those who would operate in cases of infantile paralysis, and that of those who deny the existence of a paralyzed or even muscular inco-ordination from reflex genital irritation—by showing that there are cases of anomalous and extraordinary nervous manifestations certainly dependent on some irritation of the genital organs, in which an operation is not only justifiable, but absolutely demanded, and that in many instances the relief from all the strange symptoms has not only been immediate, but permanent after the operation, without any other medical or surgical treatment. It is also equally certain that any attempt to relieve a nervous disturbance dependent on some central lesion of the brain or spinal cord would result in no benefit whatever. The views of the writer were sustained by a large number of cases occurring in the practice of physicians in different parts of the country.

SECTION IN GYNÆCOLOGY.—Tuesday, September 6th—Second day. Thomas More-Madden, M.D., Dublin, read a paper on

THE CAUSES AND TREATMENT OF BARRENNESS.

Few gynæcological questions come so constantly before us, and none probably are of greater practical importance than those connected with sterility, involving, as they do, not merely the physical health of the patient, but also in many instances affecting the happiness and welfare of married life. For, at least in the country where his practice lies, child-bearing is still generally, and he believed rightly, held to be one of the chief functions of a woman's conjugal life; while to be sterile is commonly regarded as the protean source of marital troubles.

In this paper will be found a statement of the causes of sterility in five hundred and twenty-eight of the cases of infecundity which, occurring in married women within the child-bearing period, have come under observation in the gynecological department of his hospital. The cases may be roughly divided into classes :

(1) Those in which barrenness was occasioned by sexual impotency or some physical impediment from the vulvar orifice to the ovaria. (2) Cases of true sterility, or conceptive incapacity from deficiency congenital or acquired, structural disease, arrested developments, supra-involution, etc., of the uterus, or from analogous morbid conditions of its appendages. (3) Cases of barrenness from constitutional causes. (4) Cases in which the causes of infecundity were apparently moral rather than physical, such as sexual incongruity, etc.

According to this the most frequent cause of sterility is stenosis of the cervical canal. And as he believed the operative treatment of such cases, simple as it is deemed by some, requires more consideration than it generally receives, and frequently proves worse than useless from the disregard of certain details and precautions which he considered essential, he ventured to recommend the use of a method of procedure and the adoption of instruments which he had found advantageous in the curative treatment of stenosis in three hundred and eighty cases of obstructive dysmenorrhea and sterility traceable to this cause. During the present session seventy cases have been treated in his hospital.

The essential features of the method of treatment are the separation by cutting and simultaneous forcible expansion of the affected parts, followed by dilatation during the period of cicatrization, so as to prevent their subsequent contraction, and thus to secure the permanent patency of the occluded passage. To obtain this result he used three instruments, viz., a special form of uterine director which can, generally speaking, be introduced into any cervical canal, however narrow, and along which a serrated, triangular-guarded knife is made to travel up through the os internum; and, thirdly, a uterine dilator of great power, by which any required degree of cervical expansion may be effectually secured and accurately gauged.

The influence of uterine flexions in the prevention of pregnancy and the treatment adopted in cases of sterility dependent thereon are next described. So also is the management of aphoria when it results, as is frequently the case, from chronic endometritis. The methods found most serviceable in infecundity due to vaginal, uterine, and ovarian causes are briefly reviewed. More fully dwelt on is the subject of conceptive incapacity from morbid conditions of the Fallopian tubes, as he regarded stenosis, as well as

occlusion of those ducts by vaginitis and its results, such as hydro- and pyo-salpinx, far more common causes of sterility than usually thought. He also held that such tubal diseases may often be removed without resort to the serious operative procedures, as removal of the uterine appendages, by some surgeons considered invariably necessary, and by them freely employed in such cases. Therefore he had referred at some length to those less heroic measures, such as aspiration and catheterization of the Fallopian tubes, the feasibility and successful results of which he had clinically demonstrated.

Finally, the question of sterility arising, as it not infrequently does, from constitutional disorders, and instances apparently irrespective of any physical cause, and the method of dealing with such cases, is treated of in his paper.

A. Reeves Jackson, M. D., of Chicago, Ill., read a paper on

THE MODERN TREATMENT OF UTERINE CANCER.

Correct views of pathology and accurate diagnosis form the only rational grounds for proper treatment of disease. The modern treatment of cancer is based on the theory of its local origin, and implies the possibility of its complete removal. If this theory be true, failure to cure depends upon the essential inadequacy of the means used, or their untimely or inefficient employment. All remedial means are inadequate which have not the power to remove the diseased structures. The object of the treatment may be palliative or radical, the determination depending upon the location and extent of the disease and the general condition of the patient. Palliative measures are always available, while radical measures are not always safely applicable. Medical agents taken internally may be beneficial as palliatives, but are useless, so far as we know, in removing or modifying the progress of disease.

Conclusions: 1. Any operation for cancer which does not completely remove the disease will be followed by recurrence.

2. During life the limit of cancerous disease originating in any part of the uterus cannot be known; hence no operative procedure can guarantee complete removal.

3. In view of this fact, no operation is justifiable which greatly endangers life, provided other and safer methods are available.

4. Vaginal hysterectomy is more dangerous, in a certain sense, than the disease against which it is used; that is, a given number of patients afflicted with uterine cancer will live longer without than with the operation.

5. Other methods of treatment, attended by not more than one-sixth to one-fourth the mortality of vaginal hysterectomy, are equally efficient in ameliorating the symptoms and retarding the

progress of the trouble, and they have been followed by as seemingly good results as regards recurrence. Hence they should be preferred.

6. Vaginal hysterectomy does not avert or lessen suffering; it destroys and does not save life. It is, therefore, not an useful but an injurious operation, and as such is unjustifiable.

Prof. Graily Hewitt, London, England, read a paper on

THE RELATIONS BETWEEN CHANGES IN THE TISSUES AND
CHANGES IN THE SHAPE OF THE UTERUS.

In describing uterine tissue-changes, the term "chronic metritis" is generally employed. It is desired to call attention to a tissue-change sometimes observed on or after the arrival of puberty, especially in young women who have been inadequately nourished, consisting in undue softness of the uterine tissues, and associated with the beginning of uterine suffering. This undue softness is not "inflammatory" in its nature. It is associated with great flexibility of the uterus, and generally with marked flexion. The author first described it ten years ago, and has repeatedly remarked it since. It has recently been noticed by Dr. Charles D. Scudder, under the term "mollities uteri."

The recognition of the liability to occurrences of this initial change in the uterine tissues is to be regarded as very important in the explanation of the origin and increase in degree of flexions of the uterus. In such cases the uterus being abnormally flexible, the flexion may be easily and gradually intensified by any ordinary exertion, but will be more likely to be much exaggerated and perpetuated by any severe and suddenly acting mechanical disturbance. The process by which the uterus becomes permanently flexed may thus be slow or rapid.

Hardening of the uterus occurs sooner or later. After hardening, the flexion is persistent.

In some few cases the flexion may be persistence of a congenital condition, or due to absence of developmental growth at the time of puberty, without undue softness being present.

In multiparæ a somewhat analogous condition is present, in what is known as "defective uterine involution," the uterine tissues being soft and wanting in resistance. As is generally admitted, slow flexions generally originate at such times and under such circumstances.

The author contends that the interference with circulation, present with uterine congestion, is, in most cases, due to association of a weak blood-current and mechanical compression of uterine tissue, due to flexions present in such cases. The uterus being unduly soft, plastic, and mouldable, it takes a flexed shape, which often becomes perpetuated by the hardening process

described by Jacobi as the result of chronic metritis. One consequence of the latter is the presence of sclerosis of the uterine parenchyma. It is to be remarked that the incidents of some of the cases related by Putnam-Jacobi favor the view that flexion and displacement were operative in producing the menstrual subinvolution, rather than the cervical catarrh, which Jacobi assigns as the principal cause.

SECTION IN OBSTETRICS.—Tuesday, September 6th—Second day.—Dr. J. C. Cameron, of Montreal, Canada, read a paper entitled

THE INFLUENCE OF LEUKÆMIA ON PREGNANCY.

In this he showed by a *résumé* of the literature how incomplete our knowledge of the subject still was. We knew that cases were most frequent in women, especially during pregnancy, or at the climacteric. Its effect upon the reproductive organs was but little known, and barely mentioned in any work. The disease was apt to begin during the latter part of pregnancy, and indeed, in many of those who became sallow and anæmic during pregnancy, though only temporarily so, the ratio of white to red blood-corpuscles was much increased.

The case which he reported was unique, in that pregnancy recurred successively during the progress of the disease, and was also interesting in showing a marked hereditary tendency—the parents of the patient and her six children being all leukæmic. The splenic tumor was first noticed during a pregnancy, and increased markedly in size during each successive gestation, the disease running a remarkably chronic course. A fact worthy of note was that the red blood-corpuscles of a child born when the disease was well marked were in the normal proportion in the vessels of the child, even above the normal in the placental artery, but much diminished in the placental vein, showing that the blood actually lost red corpuscles while passing through the placenta. In the placental sinuses the red globules were fewer than in the general circulation of the mother.

Prof. A. Charpentier, Paris, read a paper entitled

L'URÉMIE EXPERIMENTALE.

In this he detailed the results of certain experiments made by him on the artificial production of uræmia in gravid animals, by the injecting into the blood, at intervals, of urea until it was present in excess. In these cases the death of the foetus preceded that of the mother, and the quantity of urea in its veins was in excess of that in the mother's. The death of the foetus was caused by this excess of urea in its circulation.

Dr. William T. Lusk, of New York, presented a paper on

THE PROGNOSIS OF THE CÆSAREAN SECTION.

If it were proposed to beat out the brains of a living child, the suggestion would be received with horror, no matter how great the surgical emergency might be, and yet, with the child unborn, craniotomy was often done for insignificant reasons. A careful *résumé* of the statistics showed very favorable results, even with the old method, when the surroundings were favorable and the operation was performed with proper surgical skill and accessories. Death was most often the result of an avoidable cause. The reader compared the brilliant results obtained abroad with the mortality attending recent American operations, and thought that a more favorable prognosis could not be expected until we had learned to recognize the conditions requiring the operation before the time when it should be done.

Defective diagnosis was the great bar to progress in this country, and all practitioners should qualify themselves to recognize the various degrees of pelvic deformity. An operator should possess at least a theoretical knowledge of the technique of the procedure, and while it was not desirable that every one should attempt to perform the section, men capable of doing the operation could usually be found, even out of the larger cities.

The paper closed with a plea for Cæsarean section as opposed to craniotomy, even in pelvis with a conjugate of three inches.

Dr. M. Sanger, Leipsic, Germany, presented a paper on

THE CÆSAREAN OPERATION.

Sanger's operation was to be preferred to the Porro when the child was living and could not be delivered by any other operation, or when the child was dead and could not be delivered by craniotomy or embryotomy, or could be so delivered only with the greatest danger to the mother. Good results could be obtained by the Cæsarean section only under certain conditions, and when the operation was performed according to certain approved technical principles. These conditions are :

First. The maintenance of an aseptic condition in the uterine cavity, and, second, early performance of the operation.

Sanger thinks that the cause of the greater American mortality is delay, and only trying the section when other operations have been unsuccessful. He lays stress on the following :

First. Antiseptic precautions as in other laparotomies.

Second. The abdominal incision should be made through the linea alba, over the middle of the fundus, about sixteen centimetres long.

Third. It is not advisable to evert the unopened uterus, as it requires a large incision, except where the fœtus is dead or there are not sufficient assistants.

Fourth. The elastic ligature is not to be used before the uterus is opened, as it endangers the life of the child, or may incarcerate parts of the child, so that it may have to be loosened at a time when the operator requires his hands for more important matters.

Fifth. Open the uterus in situ, by a frontal median incision; cut through placenta, or push it to one side; extract child by the legs; if head is caught, extend incision upward, to prevent any downward laceration of the uterus. At same time assistant is to press abdominal walls toward uterus to prevent prolapse of intestines or flow of fluid into the abdominal cavity.

Sixth. The danger from hemorrhage is not so great as is commonly supposed. By pressure on the inferior segment, and by slight torsion of flexion of the uterus and broad ligaments, the bleeding can be much lessened. Do without elastic ligature if possible.

Seventh. Care must be taken in regard to three points in suturing: 1. Accurate union of the incised surface of the uterus by numerous sutures, whereby a broad and close union is obtained. 2. Avoidance of suture-canals in the uterine cavity. 3. Especially, careful union of the serous surfaces. Silk is preferred to silver wire, because silk can be absorbed. Excellent results can be obtained with catgut prepared in oil of juniper, chromic acid, or mercuric bichloride.

SECTION IN DISEASES OF CHILDREN.—Tuesday, September 6th.—Second day.—Dr. Moncorvo read a paper on

HEREDITARY SYPHILIS AND RICKETS IN BRAZIL.

In an extensive practice in Rio de Janeiro he believed that hereditary syphilis furnishes sixty per cent. of the cases of infantile disease. It is the most important factor of infant mortality, either directly or by the severity which it imparts to the diseases of children, and rickets makes its appearance in forty-five per cent. of the children that come under his observation. This does not accord with the opinion of Dr. Charles West, who stated in the Congress of 1881 that while syphilis was common in Brazil, rickets was unknown.

More than two-thirds of the rickety children in his practice show signs of syphilis, and it is rare to find an hereditary syphilitic child whose bones are not deformed by rickets.

Although not prepared to demonstrate the etiology of rickets on these grounds, he believed that hereditary syphilis is an important factor.

A paper was read by Dr. William Stephenson, of Aberdeen, Scotland, on

THE RATE OF GROWTH IN CHILDREN.

But little had heretofore been known in regard to the rate of growth in children, and nothing whatever of its clinical bearings. Many important questions arise in this connection. For instance, if a boy in a given year adds to his weight double or treble the number of pounds which he does in another year, is he on account of this increase of cell-activity the more or the less able to bear a strain, such as school pressure or physical labor?

By combining the tables of Dr. Bowditch and those of the Anthropological Committee of the British Medical Association, Dr. Stephenson had tried to construct a standard of the rate of growth from the fifth to the eighteenth year, for all the English-speaking races.

In the charts exhibited, the graphic line representing the annual increase in weight presents a curve of similar type in girls as in boys, but differing in the times of maxima and minima. The most striking difference is seen in the fact that the maximum rate of growth occurs in girls from the eleventh to the thirteenth year, and in boys from the fourteenth to the sixteenth year.

From his study of the tables and charts the author is of the opinion that the critical and trying character of the period known as puberty is due to the fact that the great activity of growth, which occurs then, makes a serious demand on the system, rather than to the fact that the reproductive organs are about to reach complete development. Reference was made to important results to be obtained from comparisons in rate of growth between children of the poor and rich, and of the professional, commercial and artisan classes.

A paper was read by Prof. Victor C. Vaughan, of Michigan, on
THE USE OF COW'S MILK IN THE ARTIFICIAL FEEDING OF INFANTS.

Three years ago the writer had isolated the active principle from poisonous cheese. He had named it tyrotoxinon. Later he found the same principle in milk, ice-cream, and other articles of food. In experimenting with this poison it was found that its action on the lower animals produced the phenomena of cholera infantum. The symptoms and the post-mortem appearances were identical. From this it is easy to understand the prevalence of cholera infantum among the very poor, where fresh, wholesome milk is almost unknown.

Not a few medical teachers advise the prohibition of milk during the progress of cholera infantum, basing their opinions on clinical experience. The same view had been reached by the author of the paper through a long series of laboratory experi-

ments, which show that normal milk inoculated with a small portion of poisoned milk and kept a few hours at the temperature of the body becomes itself poisonous.

SECTION IN GYNÆCOLOGY.—Wednesday, September 7th.—Third day.—Dr. Ernest W. Cushing, of Boston, read a paper entitled

CANCEROUS DEGENERATION OF THE HYPERPLASTIC GLANDS OF THE CERVIX UTERI.

Ruge and Veit have described a condition of the glands which they considered to be in itself the nature of a cancer—a transition from innocent to malignant formation. This seems to me much less clearly demonstrable than the views which they maintain concerning erosion. Briefly, they attribute the greater import to a certain filling up of the lumina of the glands with epithelial cells, either columnar or flat. The fascinating theory of Veit and Ruge agrees so thoroughly with Theirsch and Waldeyer and their followers that it has been very widely accepted, and a plate showing the transition is shown in Dr. A. Martin's "Gynæcology." I think it possible that greater importance has been attached to this condition of glands than has been warranted. The question is of practical importance in regard to the microscopical diagnosis of suspicious affection of the cervix, for as it is admitted that the diagnosis cannot be made securely by the unaided eye nor by the touch, and as vaginal hysterectomy is now advocated, and, at any rate, free amputation of the portio vaginalis is indicated in all cases of undoubted cancer, even in an incipient stage, a great responsibility is thrown on the microscopic examination.

In the first place, as Ruge and Veit expressly declare, in the majority of cases the carcinoma did not originate in the new-formed gland, but infiltrated the cervix as a "carcino-sarcoma," an aggregation of small cells lying in masses in alveoli of connective tissue. In such cases there was no evident connection with the epithelium of the surface with the glands. In four out of twenty-two beginning cancers of the cervix, however, they found appearances of solidification of the glands and filling up with epithelium, which they describe and figure as a transitional stage in the development of the adjacent cancer. With much diffidence I venture to suggest that my studies of the changes in question have led me to different conclusions from these observers. The plates of Ruge and Veit are not conclusive on this point.

Even when a whole series of glands lying adjacent to each other show occluded lumina on section, I cannot feel the diagnosis of carcinoma is justified, but only that of adenoma. It may become destructive, but is not carcinomatous until changes occur in the

connective tissue between the glands, when the boundaries of the glands are broken through by the growing cells.

Even when the new glands are thus involved manifestly in the carcinomatous growth, it has seemed to me they are invaded from without by the growth of cells in the surrounding tissue. . . . I have found no evidence that after filling up the lumen of a gland the proliferating columnar epithelium changes to the flat variety, and, breaking through the boundary of the gland, invades the surrounding tissue.

Moreover, in attributing so much importance to the fact that they found the lumina of some of the new glands occluded, Ruge and Veit have not noticed the explanation that precisely these solid acini or branches may be the first stage of their existence previous to the formation of the lumen.

Such a mode of growth is seen in the formation of new glands in the walls of a multilocular cystoma of the ovary. These little solid sprouts, lined with columnar epithelium, afterward become hollow and then dilate, forming cysts.

A similar mode of growth is seen in the female breast when rapidly enlarging, preparatory to the secretion of milk.

Where the microscope shows glandular degeneration, the surface bare of epithelium, the tissues heavily infiltrated with small cells, especially if the woman be fifty or over, we should not say that the microscope only shows chronic inflammation, but that while cancer is not proved, it is not excluded, and should recommend a free removal or destruction of the suspected tissue.

Shall we, then, say that a case is not cancerous which shows no distinct structure of carcinoma on microscopic section, only a glandular hypertrophy, with some of the glands filled with epithelia, and the stroma infiltrated with small cells, the surface denuded of its epithelial cells and irregular?

May we not reconcile the long contest between the two theories, which assign the origin of cancer respectively to the connective tissue and to the epithelial layer of the glands of the involved organ, by supposing that the anatomical arrangement of cells, which clinically and microscopically we call cancer, is only the visible and outward sign of a morbid agent at present hidden from us?

The practical deductions which depend upon our speculative opinions as to the nature of cancer are of the greatest importance.

In the first place, if the disease comes from within, if it is a perverted growth of a part of the tissues, dependent on some original error of development, it is necessarily absurd to try to find, empirically, any medicine which should cure it.

If, however, it is an infection of some kind from without, we

are justified in trying empirically, if as yet vainly, for some remedy which may overcome it.

Of more practical importance is the question of the utility of cauterizing the stump or cavity from which a cancer has been removed. There is considerable evidence which shows that surgical interference with a cancer is sometimes followed by a recrudescence of the disease more rapid and violent than the original disorder. If we consider that the operation opens veins and lymphatics which sometimes become infected with the morbid agent, we can better understand why a thorough cautery of the tissues left bare by the removal of a cancer of the cervix should be apparently so useful in lessening the chances of a return of the disease.

Dr. Leopold Meyer, Copenhagen, Denmark, read a paper on

CONTRIBUTIONS TO THE PATHOLOGY OF INFLAMMATION OF THE
LINING MEMBRANE OF THE UTERUS (ENDOMETRITIS COR-
PORIS CHR.).

1. (a) In cases of chronic endometritis, as a rule, we find two varieties of cells, or, rather, of nuclei (as the limits of each single cell are often not distinct) in the inter-glandular tissue. One variety has smaller nuclei; these average as large, or a little larger, than red blood-corpuscles, are stained brightly by hæmatoxylin, carmine, Bismarck-brown, and the substance of the nucleus rarely presents a granular condition.

The second variety has a great resemblance to the so-called decidua-cell.

(b) This second variety of cells is not only found in cases where the woman has been pregnant, but is seen in the most developed forms in women whose virginity is unquestionable.

(c) This second variety of cells seems, as the first variety, to be derived from the cells normally found in the inter-glandular tissue of the lining membrane of the uterus, the decidua. Cells of the second variety are found in the normal lining membrane during menstruation.

(a) Besides these two kinds of cells, we find regular connective-tissue cells and white blood-corpuscles in the inter-glandular tissue.

2. In cases of chronic endometritis the epithelium covering the lining membrane of the uterus can preserve its character of a low columnar epithelium, but it frequently changes character altogether.

SECTION IN OBSTETRICS.—Wednesday, September 7th.—Third day.

DISCUSSION ON CÆSAREAN SECTION.

Prof. Alexander Simpson, of Edinburgh, Scotland, was in accord with the views expressed in Dr. Lusk's paper, though he did not think the time had yet come when craniotomy could be entirely laid aside; its performance, however, should be restricted. In Edinburgh pelvic deformity was rare, and craniotomy was rarely required. The cases requiring abdominal section could be divided into two groups—first, those where the prognosis was rendered grave by pre-existing inflammatory conditions or sepsis, and second, those favorable cases where we could choose the moment and place of operation, when we should nearly always succeed. At present he would be bold who would perform Cæsarean section by other than the Säger method. Where the uterus was diseased and its removal would give the patient a chance he would employ Porro's method.

Professor August Martin, of Berlin, Germany, considers the Säger modification very important, and one which has rendered the operation safe. Since the adoption of this modification the section had been done in some cases where he thought version could have been safely performed. In moderate degrees of pelvic contraction we should ascertain whether delivery could not be effected in other ways, as by version, before performing the section. Had done the Cæsarean in pregnancy complicated with cervical myomata. Säger had operated in similar cases. Where carcinomata of the organs in the pelvis endangered life we should endeavor to deliver child and remove growth at the same time. When the uterus was infected by septic material it should be removed. In a rachitic kyphotic woman, with heart and lung disease, the symptoms were so grave that he did not think the woman would stand normal parturition or the puerperal state; accordingly he had done abdominal section, saving both child and mother, who finally died from her lung trouble. Much depended upon our knowledge of the technique; if we succeeded in doing the operation perfectly, either the Säger or Porro operation was justified. The statistics of the Porro operation were rendered less favorable by Italian operations done on unfavorable subjects who were septic and in whom the operation was too long delayed. The Cæsarean section always gives us hope of perfect recovery, while the Porro operation prevents future maternity.

Abdominal section is indicated when it seems impossible to bring a living child through the pelvis (take care not to operate too soon); when neoplasmata narrow the canal or endanger the progress of parturition; and when diseases are present in which the life of mother and child would be endangered by the process of parturition or the puerperium.

The Cæsarean section should be done when we have reason to believe that the patient can endure another pregnancy; the Porro operation, or total extirpation, when there is no hope of future maternity or where the disease, from its nature or seat, is probably fatal.

Dr. W. W. Jaggard, of Chicago, Ill., said, with reference to the *relative indication* for Cæsarean section, that in cases where the child could pass *per vias naturales*, when diminished in volume, with safety to the mother, as, for example, in pelvic contractions of from 6 to 8 ctm. in the true conjugate, four considerations should receive attention:

First. Craniotomy does not require a higher degree of operative skill than every qualified obstetrician ought to possess, when proper instruments are employed, *e. g.*, Braun's curved trepan and cranioclast.

Second. The mortality of craniotomy, when performed in time, and before exhaustion and infection of the woman, with adequate skill and antiseptic precaution is, as remarked by Barnes, practically nil.

Third. The consent of the woman, obtained without direct or indirect coercion, an essential condition of the relative indication, is seldom gained, if the facts be presented to her.

Fourth. That there is much sentimentalism with reference to the value of the life of the child in utero, as compared with the value of the life of the mother. This interest in the child is purely impersonal and scientific. The delight in saving the child's life is frequently that arising from the success of a difficult scientific experiment.

Dr. William T. Lusk, of New York, said that the points made by Dr. Jaggard were opposed to his recent investigation. With skill we could remove a living child where the contraction was only 7 to 10 ctm. Craniotomy was a dangerous operation, and, under three inches, required much skill and good instruments. He believed the Cæsarean section not more dangerous than the extraction of the child after craniotomy. In his recent case the operation was done in the open ward, with the same preparations as for ordinary laparotomy. The children, according to his researches, did not die, as general opinion would have it. The Cæsarean section was easy to do. He thought there was danger, in the employment of the elastic ligature, from paralysis and inertia, caused by the compression. We did not want to encourage trying craniotomy and then Cæsarean section, but should make the latter the operation of election. Most of our cases had been done under circumstances which had rendered death inevitable.

SECTION IN DISEASES OF CHILDREN.—Wednesday, September 7th.—Third day.—Dr. Cyrus Edson, of New York, read a paper on

THE MILK-SUPPLY OF CITIES,

calling attention to the great importance of improving and maintaining the standard of milk-supply by banishing adulterated and infected milk. He advocated the examination by veterinary inspectors, from time to time, of every herd of cattle in the State, in order to secure the destruction of all animals suffering from tuberculosis, and the quarantine of those liable to cause contagious disease. A paper was read by Dr. Paul Redard, of Paris, on

THE TREATMENT OF ERECTILE TUMORS BY ELECTROLYSIS.

He described in detail the method proposed by Ciniselli de Cremorne, which, with some modifications, he had found satisfactory in a large number of cases in dispensary practice. The operation is moderately painful, and the effect rapid, with no suppuration or scars.

Dr. Isaac N. Love, of St. Louis, Mo., read a paper on

INFANTILE MARASMUS.

He reviewed a class of cases distinct from those caused by tuberculosis, syphilis, and intestinal catarrh. In an advanced stage they present a picture the principal features of which are wasted muscles, prominent bones, a loose and dry skin, and face withered, wrinkled and worn. A careful study of a large number of such cases had suggested to him the following conclusions :

1. Infantile marasmus is dependent primarily on torpidity and inactivity of the glandular system, and is aggravated by unsuitable, over-abundant, or insufficient food and insanitary surroundings.

2. It is of the first importance, in treatment, to arouse secretion and excretion, the best remedy being calomel in one-twentieth of a grain doses, with the free administration of water ; both of these agents exciting glandular action, stimulating the secretion of the digestive juices, and promoting diuresis and intestinal secretion.

3. In the matter of diet, the mother's milk is the best, and some other mother's milk the next best.

4. In extreme cases, administer soluble foods in the form of baths, and practice gentle friction and massage, with an occasional bath in water containing a diffusible stimulant.

A paper was read from Dr. William Henry Day, of London,
SOME OBSERVATIONS ON HEADACHES IN CHILDREN, AND THEIR
RELATION TO MENTAL TRAINING.

The writer considered the characteristics of nervous frontal and neuralgic headache, and the condition known as irritable brain

One form or the other is the first and most persistent symptom of the breaking down which follows the mental over-pressure which now prevails in education and in the competitive examinations for entrance in every profession and in every branch of the public service. The irritable brain is not infrequently accompanied by myopia, hypermetropia, and astigmatism.

SECTION IN GYNÆCOLOGY.—Thursday, September 8th.—Fourth day.—Dr. August Martin, of Berlin, Germany, read a paper on

VAGINAL TOTAL EXTIRPATION OF THE UTERUS FOR CANCER.

Freund inaugurated the extirpation of the cancerous uterus ten years ago. Sufficient material is now at hand to decide the two following questions, which may legitimately be asked concerning every new method of surgical treatment: 1. Is this operation practicable with such immediate success that it promises good results in the hands of others than a few specially successful operators?

2. Does the extirpation of the cancerous uterus give permanent results which force us to recognize that this method is superior to any other treatment of cancer employed up to the present time?

In seeking an answer to the first, if they examined the literature, they would be struck with the fact that only meager and isolated reports about this operation could be found in English and German medical journals. Vaginal extirpation had obtained decided recognition in Germany. In this country the purely vaginal operation of Czerny and Billroth and Schroeder had been adopted instead of the procedure of Freund, which was a combination of abdominal and vaginal operations. The results of the same have improved noticeably with increasing exercise and experience.

In 1881 Olshausen collected forty-one cases, with twenty-nine per cent. mortality. In 1883 Sänger, one hundred and thirty-three cases, twenty-eight per cent. mortality. In 1884 Engström, one hundred and fifty-seven cases, twenty-nine per cent. mortality. In 1886 Hegar, two hundred and fifty-seven cases, twenty-eight per cent. mortality. Through the courtesy of these operators, who to his knowledge commanded the greatest amount of material, and, at his request, placed at his disposal the results up to the end of the year 1886, he was able to present the following: Up to the end of 1886 these total extirpations had been performed on account of carcinoma uteri: Fritsch, sixty times, with seven deaths; Leopold, forty-two times, four deaths; Olshausen, forty-seven times, twelve deaths; Schroeder (Hofmeir), seventy-four times, twelve deaths; Staude, twenty-two times, one death; A. Martin, sixty-six times, eleven deaths. Total, three hundred and

eleven cases, with forty-seven deaths, or 15.1 per cent. Were they not justified in assuming that this rate of mortality would decrease with more experience, as shown by the published tabular results of each of these operators? Already the total extirpation of the uterus for cancer showed better results, so far as immediate mortality is concerned, than removal of the breast for cancer.

For the latter, Küster, at the twelfth meeting of the German Surgical Society, in 1883, published seven hundred and seventy-eight cases with a mortality of fifteen and six tenths per cent. Who would hesitate to propose to perform the amputation of the cancerous breast so soon as the diagnosis is established?

He did not hesitate to answer his first question in the affirmative, and to claim for this operation of the vaginal total extirpation of the uterus a full and equal rank among all methods for the treatment of cancer of this organ. For an answer to the second he would make use of the relatively small, but very accurately reported cases of Schroeder, collected by Hofmeir, and those of Fritsch, Leopold, and himself. They show that the permanent results of vaginal extirpation in this relatively short period of observation were no doubt equal to the best results of carcinoma operations of other organs.

The author up to the end of 1885 operated on forty-four cases. Of these, eighteen relapsed, or twenty nine and seven tenths per cent.; recovered, thirty-one, or seventy and three tenths per cent. Was there any other method of treating cancer, which with so small mortality could show equally good results? There was no other mode of treating cancer of the fundus and those forms of diseases of the cervix in which the mucous lining of the cervical canal was the point of origin, or in which there were carcinomatous nodules in the tissues of the neck. There was no room for discussion except in epithelioma of the portio vaginalis arising from the surface of the cervix, that is, from a surface covered with flat epithelium and containing very few glands. He agreed with Fritsch that the observation of cases of progress of the disease in isolated nodules in the mucous membrane up to the fundus, in cases of carcinoma colli, is sufficient in itself to show it was erroneous to claim that in carcinoma of the cervix we should try to save the body of the uterus. Binswanger and P. Ruge have described such well-marked cases. The possibility of a subsequent pregnancy was not excluded in cases of high excision; but Hofmeir himself declares that pregnancy is a very serious danger in carcinoma. Therefore he was convinced that it is much better to immediately perform vaginal total extirpation in these forms of epithelioma of the cervix. The sooner they operated the more surely they might hope to save their patients from the sad fate of death by cancer. The greater the experience with

vaginal total extirpations the more has the rule been proved that we should perform the operation only when the vicinity of the uterus is entirely free from carcinomatous infiltration. All attempts to enlarge the boundaries of the operation in this direction had failed. The technique of the operation had undergone only immaterial changes, as is shown by the results of operators using different methods. It was irrelevant whether the uterus be removed by an incision made in front or at the side of the neck, or behind it. It was of little importance whether hæmorrhages be prevented by stitches introduced before the incision, or whether each separate vessel be seized and tied as it bleeds. It was immaterial whether the uterus be turned over or removed by drawing it down and freeing it; whether the opening in the floor of the pelvis remain open or be closed, or be drained either with the iodoform gauze or with a tube. If it were easily practicable he advised that the ovaries and tubes be also removed. It was immaterial whether the wound be sutured or not. It was wonderful what little impression the operation made on the patient. One could liken her very much to a puerperal woman. Bleeding must be stopped, at all events during convalescence, and the parts as much as possible kept at rest. Washing out the peritoneal cavity does not work favorably.

SECTION IN OBSTETRICS.—Thursday, September 8th.—Fourth day.—Dr. E. H. Trenholme, Montreal, Canada, presented

INTERNAL UTERINE HÆMORRHAGE THE RESULT OF OVERDISTENTION OF THE UTERUS FROM HYDRAMNIOS.

The author pointed out some of the causes of hydramnios and the serious results of such distention. The distention caused a deficient nutrition of the decidua, which allowed it to rupture, causing hæmorrhage from the site of the tear. The blood might clot *in situ* or pass between the layers of the decidua. The hæmorrhage began with severe pain and sense of fullness, with signs of internal hæmorrhage. Cited case. We should forestall the danger by causing premature labor before the hæmorrhage occurred, that is, as soon as the distention becomes excessive. Should bleeding have occurred, it is necessary to wait until the vessels have closed before we attempt treatment.

Dr. John Bartlett, of Chicago, Ill., presented

A STUDY OF DEVENTER'S METHOD OF DELIVERY OF THE AFTER-COMING HEAD.

Deventer's method was shown to consist of a reversal of the so-called Prague method, in that the body of the child was carried far backward toward the perineum, with the view of turning

the occiput out from under the pubes, the anterior surface of the neck resting on the perineum. At the beginning the occiput of the child was turned forward, so as to come under the pubes as the child was drawn down. The arms were not to be drawn down, but left up alongside the head, being placed so as to come anterior to either parietal base. The delivery by traction backward upon the body was to be aided by pressure made immediately above the pubes, the wedge formed by the head and arms being decomposed by the withdrawal of the larger transverse diameter of the head from between the arms, as descent of the head accompanied by extension occurs. The mechanism was only favorable when the occiput was anterior. Deventer never lost a child or tore a mother. The arms being left up, protected the neck of the child and allowed a passage for the cord alongside of them, so that haste was not as necessary as with ordinary methods, and, occupying a broad and yielding part of the pelvis, they did not obstruct delivery. The method was a plausible one, and certainly worthy of trial in suitable cases.

Dr. J. E. Kelly, New York, read an elaborate paper, entitled

LITHIASIS IN PREGNANCY.

Being impressed by the frequency, during gestation, of many of the arthritic, gastric, and other phenomena which ordinarily are present in lithiasis, the author reviews in detail the relations existing between the two conditions, and concludes that the association is due to the correspondence of the condition of the blood in lithiasis and pregnancy. First considering the general pathology of lithiasis, and subsequently that of the various systems, he then investigates the phenomena of pregnancy, and indicates the influences which produce, in the maternal blood, a condition almost identical with that which is present in lithiasis, and draws a parallel between the diseased conditions most frequently observed in pregnancy and the symptoms of lithiasis. These investigations would suggest the careful supervision of the condition of the pregnant female, especially with regard to the digestive, circulatory, and urinary symptoms, and, in suitable cases, the intelligent application of prophylaxis.

SECTION IN GYNÆCOLOGY.—Friday, September 9th.—Fifth day.—Dr. Henry O. Marcy, Boston, read a paper on

HISTOLOGY AND SURGICAL TREATMENT OF UTERINE MYOMA.

He presented an interesting array of micro-photographs. He showed the multilocular growth, the capsule, the multilobular growth, and the parts at which they lie in juxtaposition; the

histological relation of the growth to the uterus; the vascularization; the first injection they were able to make into a fibroid tumor; and discussed the bacilli discovered by Dr. Nelson, of Boston, which he termed *bacillus Nelsoni*. He showed a number of other cuts, and the specimen of a tumor which he had removed from a woman *per vaginam*, but which he would not attempt again, on account of its size; exhibited some instruments for the operation of removal of fibroid tumors, of his invention, and discussed the shoemaker's stitch.

A paper by Dr. M. D. Spanton, of Hanley, England, was read by Dr. Edoes, of Manchester, England, on the subject of cystitis in woman. Local conditions leading to cystitis in women, among which are enumerated diseased states of the uterine appendages, bands of adhesions dragging upon the bladder, and some of the affections causing obstruction to the passage of the urine, which are often obscure and trivial in themselves, are not infrequently overlooked.

Dr. William L. Reid, of Glasgow, Scotland, read a paper on the remote results of shortening the round ligaments. He had performed the operation eighteen times. He gave the opinions of the authorities, mostly British, and which were mostly unfavorable to the operation. The discussion which followed this paper was rather unfavorable to the operation.

SECTION IN OBSTETRICS.—Friday, September 9th.—Fifth day. The committee appointed to formulate resolutions in regard to uniformity in obstetrical nomenclature submitted its report, which, after an animated discussion, was unanimously accepted, the only dissentient being Dr. Martin, of Berlin, who was not present, but had left a message stating that he thought the matter should not be settled by an American Congress, but should wait three years and be accepted or not by a Congress meeting in the Old World.

A. It is desirable to try to attain to uniformity in obstetrical nomenclature.

B. It is possible to arrive at uniformity of expression in regard to: 1, The Pelvic Diameters; 2, The Diameters of the Fœtal Head; 3, The Presentations of the Fœtus; 4, The Positions of the Fœtus; 5, The Stages of Labor; 6, The Factors of Labor.

C. The following definitions and designations are worthy of general adoption by obstetric teachers and authors:

I. Pelvic Brim Diameters.—1. Antero-posterior; (1) Between the middle of the sacral promontory and the point in the upper border of the symphysis pubis crossed by the *linea terminalis*—*Diameter Conjugata vera*, Cv. (2) Between the middle of the promontory of the sacrum and the lower border of the symphysis pubis—*Diameter Conjugata diagonalis*, Cd. 2. Transverse: Be-

tween the most distant points in the right and left ileo-pectineal lines=*Diameter Transversa*, T. 3. First Oblique : Between right sacro-iliac synchondrosis and left pectineal eminence=*Diameter Diagonalis Dextra*, D. D. 4. Second Oblique : Between left sacro-iliac synchondrosis and right pectineal eminence=*Diameter Diagonalis Læva*, D. L.

II. Fœtal Head Diameters.—1. From the tip of the occipital bone to the centre of the lower margin of the chin=*Diameter Occipito-Mentalis*, O. M. 2. From the occipital protuberance to the root of the nose=*Diameter Occipito-Frontalis*, O. F. 3. From the point of union of the neck and occiput to the centre of the anterior fontanelle=*Diameter sub-Occipito-Bregmatica*, O. B. 4. Between the two parietal protuberances=*Diameter Bi-Parietalis*, Bi-P. 5. Between the two lower extremities of the coronal suture =*Diameter Bi-Temporalis*, Bi-T.

III. Presentation of the Fœtus.—The *presenting part* is the part which is touched by the finger through the vaginal canal, or which, during labor, is bounded by the girdle of resistance. The *occiput* is the portion of the head lying behind the posterior fontanelle. The *sinciput* is the portion of the head lying in front of the *bregma* (or anterior fontanelle). The *vertex* is the portion of the head lying between the fontanelles and extending laterally to the parietal protuberances.

Three groups of presentations are to be recognized, two of which have the long axis of the fœtus in correspondence with the long axis of the uterus, while in the third the long axis of the fœtus is more oblique or transverse to the uterine axis. 1. Longitudinal : (1) Cephalic, including—vertex and its modifications ; face and its modifications ; (2) pelvic, including—breech ; feet. (3.) Transverse or trunk, including shoulder, or arm and other rarer presentations.

IV. *Positions of the Fœtus*.—The positions of the fœtus are best named topographically, according as the denominator looks—first, to the left or the right side, and second, anteriorly or posteriorly. When initial letters are employed it is desirable to use the initials of the Latin words.

In the case of Vertex positions we have : Left Occipito-Anterior = Occipito-Læva-Anterior, O. L. A. Left Occipito-Posterior = Occipito-Læva-Posterior, O. L. P. Right Occipito-Posterior = Occipito-Dextra-Posterior, O. D. P. Right Occipito-Anterior = Occipito-Dextra-Anterior, O. D. A.

The Face positions are : Right Mento-Posterior = Mento-Dextra - Posterior, M. D. P. Right Mento-Anterior = Mento-Dextra-Anterior, M. D. A. Left Mento-Anterior = Mento-Læva-Anterior, M. L. A. Left Mento - Posterior = Mento - Læva-Posterior, M. L. P.

The Pelvic positions are: Left Sacro-Anterior=Sacro-Læva-Anterior, S. L. A. Left Sacro-Posterior=Sacro-Læva-Posterior, S. L. P. Right Sacro-Posterior=Sacro-Dextra-Posterior, S. D. P. Right Sacro-Anterior=Sacro-Dextra-Anterior, S. D. A.

The Shoulder presentations are (left and right side of the mother): Left Scapula-Anterior=Scapula-Læva-Anterior, Sc. L. A. Left Scapula-Posterior=Scapula-Læva-Posterior, Sc. L. P. Right Scapula-Posterior=Scapula-Dextra-Posterior, Sc. D. P. Right Scapula-Anterior=Scapula-Dextra-Anterior, Sc. D. A.

V. *The Stages of Labor.*—Labor is divisible into three stages: (1) First stage—from the commencement of regular pains till complete dilatation of the os externum=Stage of Effacement and Dilatation. (2) Second stage—from dilatation of os externum till complete extrusion of child=Stage of Expulsion. (3) Third stage—from expulsion of child to complete extrusion of placenta and membranes=Stage of the After-birth.

VI. *The Factors of Labor are*—(1) The Powers. (2) The Passages. (3) The Passengers.

(Signed)

DE LASKIE MILLER, M.D.,

President of the Section.

A. F. A. KING, M.D.

WILLIAM T. LUSK, M.D.

A. R. SIMPSON, M.D.

Dr. W. W. Jaggard, of Chicago, called attention to the following propositions concerning post partum hæmorrhage:

First. Late ligature of the cord is always indicated in the interest of the child—when not contra-indicated in the concrete case. The researches of Budin have demonstrated that when the cord is ligatured when it ceases to pulsate the child receives seventy-five grammes of blood—lost when the pulsating cord is tied. The relation of late ligature of the cord to the prevention of post-partum hæmorrhage is of great interest, if it be a fact.

Second. The best preventive of post-partum hæmorrhage is to secure retraction of the uterus, by keeping the hand on the fundus uteri from the moment the child begins to pass through the vulvar outlet until the muscular fibers have rearranged themselves—about one hour after expulsion of the placenta.

Kucher, in his admirable book, has called attention to friction over the fundus twice daily during the first two days of the puerperium. This is the practice in Vienna. There is little danger of dislodgement of a clot in the uterine sinuses, or interruption of the process of puerperal thrombosis, by this procedure. It is also an excellent prophylactic against resorption of septic matter.

Dr. George Wheeler Jones, of Danville, Ill., read a paper on

DYSTOCIA FROM RIGIDITY OF THE CERVIX AND ITS MANAGEMENT.

After a consideration of the various conditions which might cause rigidity of the cervix, he spoke of the most important—spasmodic contraction. Here opium was most valuable, together with chloroform and Barnes's dilators, if quick dilatation was necessary. Sitz baths, warm vaginal douches, delivery in a warm room, morphia hypodermatically, quinine where there was malaria, salicine in rheumatic cases, and electricity were all useful. He would never use chloral, as it was dangerous to mother and child. He then detailed some original investigations into the medicinal action of *gossypii radix*, *delphinium*, and *ippecacuanha*.

Dr. A. F. A. King, of Washington, D. C., called attention to the fact that the thinning of the uterine segment and the obliteration of the cervical canal, conditions which led to the rigidity of the cervix, were abnormalities. When the uterus and child maintained during pregnancy their normal lateral obliquity, the canal of the cervix from the external to the internal os will remain unobliterated until full term, which is the normal condition both for primiparæ and multiparæ. Under the same normal circumstances the great thinning of the lower uterine segment, the tearing of the decidual mucous membrane, the "formation of a new cervical canal," and the other tissue-changes observed by Bandl, will be absent during pregnancy. They are abnormal. They may nevertheless occur during labor from abnormal mechanical obstruction to delivery. Dr. King also objected to the use of chloral.

Dr. Brooks H. Wells, of New York, did not agree with Dr. Jones concerning the great danger to the unborn child from the use of chloral. In about one hundred cases out of between six and seven hundred which he had had under his charge, or had witnessed, it had been used both as an anæsthetic, where the first stage had been unusually painful, and in spasmodic rigidity of the cervix, and in no case had he seen any harm accrue to mother or child, but only the most gratifying results. He always used the precautionary measure mentioned by Dr. Jaggard, viz., to keep himself informed of the condition of the uterus by a hand placed over the fundus, slight rotary friction overcoming any possible tendency to relaxation, and had never had any serious post-partum bleeding, either with or without the use of chloral. Its administration might, in full doses, blunt the pains somewhat. He was accustomed to administer the drug in ten to fifteen grain doses, by mouth or rectum, until this result was attained—usually from two to four doses. He considered morphia and the hot douche important agents in treating the class of cases mentioned.

A paper by Dr. John H. Wilson, of Chicago, Ill., entitled "Puerperal Uræmic Amaurosis," was read by title.

The Section then adjourned, after passing a vote of thanks to Professor Simpson for the felicitous and able manner in which he had presided.

ABSTRACTS.

PROLAPSUS UTERI AND ITS ETIOLOGY.—Abstract of a lecture given at the Charité Hospital by Professor Trélat.

We do not yet know very well the mode of production of prolapsus uteri. The cause most generally admitted is elongation produced by a series of confinements. This is not, however, the necessary cause. Thus, in the clinic of M. Trélat, he had, at the beginning of June, a woman who had had eighteen children, and it was following the first pregnancy that she had had prolapsus.

It is in anatomy one should seek the manner in which these procidentias are produced.

Two series of organs co-operate in fixing the internal organs of generation of the female: First, the aponeuroses of the perineum; second, the levator ani muscles. We must not forget also the adherences which unite the organs between them. If the aponeuroses are distended or torn, if the levator ani muscle is affected by paresis, or if the muscular tonicity is diminished, it produces in these two cases prolapsus. But to produce it, there must be a strain, a violent impulse coming unexpectedly, and completing the predisposition which the subject might have, following confinements, from natural feebleness, etc.

Simple prolapsus of the uterus is rare, it is generally complicated with a falling of all the organs, bladder, rectum, etc. But there are cases, however, where the uterus alone has fallen, others where rectocele and cystocele exist without there being prolapsus uteri; in short, these mixed cases have been signal. Professor Trélat cites many observations which are personal.

All these questions are modern: Boyer only gives the description, Astley Cooper confounds them with vaginal hernia. The peritoneum can well, in fact, descend under the mucous membrane of the vagina to form a sac where the intestines engage, but this vaginal hernia, properly called, has absolutely no connection with simple rectocele or that complicated with prolapsus uteri.

P. Churchill, himself, makes a distinction between the affections of the uterus and rectoceles and cystoceles, which he places among affections of the vagina.

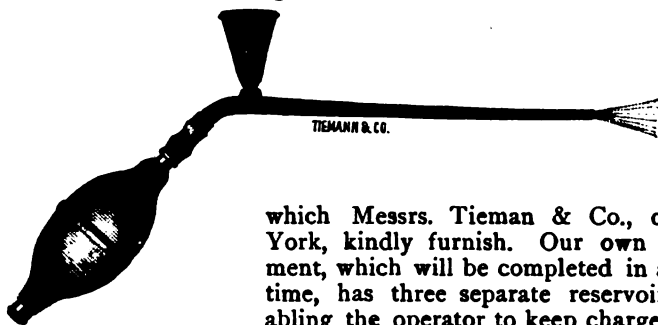
Huguier, in 1860, has revolutionized this chapter of pathology. For him, falling does not exist, all is reduced to hypertrophic elongations. Certainly there might be a complication of hypertrophy, but his general assertion was an exaggeration.

The most important point is that these investigations have

brought a new era in diagnosis and, in consequence, also in treatment.

A finger placed in the anus makes known rectocele ; a catheter in the bladder, cystocele. If the finger in the rectum perceives a tumor into which it cannot enter, but easily reducible, and re-appearing from a cough, we have to do with a vaginal hernia.—*Gazette de Gynecologie*.

INSUFFLATION.—We give a cut of the Kelly powder blower,



which Messrs. Tieman & Co., of New York, kindly furnish. Our own instrument, which will be completed in a short time, has three separate reservoirs, enabling the operator to keep charged three different kinds of powder, usually as many as are used in ordinary gynæcological practice.

THE TREATMENT OF ENDOMETRITIS EXFOLIATIVA (MEMBRANOUS DYSMENORRŒA) BY REPEATED STIMULATION OF THE UTERINE MUCOUS MEMBRANE (J. CHERON, Paris.)—In endometritis exfoliativa (membranous dysmenorrhœa) repetition is so much the rule that the more recent treatises on gynæcology do not hesitate to consider it incurable, in spite of the most energetic surgical interventions, curetting, scraping, applications of caustic, cauterization with a red hot iron, etc.

For some years I have employed the following process which has already given me rapid and lasting results. After having reduced the congestion of the utero-ovarian apparatus by the help of scarifications, osmotic dressings, prolonged hot irrigations, and having toned up the organism with the help of sulphur internally (the patients with endometritis exfoliativa are always arthritic), with baths of barége, or by hydrotherapy, I introduce, two or three times a week, a cutting curette which I carry up to the fundus of the uterus, and which I bring back scraping to the isthmus. Following this I use immediately an intra-uterine wash with about a gallon of a hot (40 C.) solution of picric acid, 4-1000.

In the fifteen or twenty days following menstruation the curette brings nothing ; the mucous membrane is clearly adherent. It only produces simply an energetic stimulation of the organ. When

the period is imminent and the curette begins to bring some shreds, I suspend the introduction of this instrument which I begin to use again some days after the period ceases. Under the influence of this treatment the membrane expelled becomes more and more slight, less and less voluminous, and more and more fragmentary.

Soon, there is no more than the slightest debris of detached membrane which does not take long to completely disappear.

The good results given by this means justifies the idea of authors who consider membranous dysmenorrhœa as the result of a congestive exfoliation of apoplectic form, since it is by an energetic stimulation of the centers of vaso-motor innervation that it is diminished; in short, the expulsion of the endometrium is suppressed.—*Gazette de Gynécologie*.

ON PAPILLARY CYSTS AND PAPILLOMATA OF THE OVARIES. By DR. W. NETZEL (*Journal Mensuel de Médéc. et de Pharm.*)—Cysts of the ovary are, we know, divided into two principal kinds: glandular cysts and papillary cysts. The first are, in comparison to the second, much more frequent. The author gives an exact description of them and makes known their principal anatomical qualities. First he shows that the liquid of papillomatous cysts contains albumen in abundance, but little or no viscid or slimy matter as we observe in glandular cysts. It is also very frequent that these tumors are closely adherent to the surrounding organs, from which it results that we are often obliged to renounce their extirpation or to content ourselves with removing them in part. In short, the bilateral form is the most typical character, and one which denotes a certain gravity of the tumor.

Concerning the diagnosis, the author has never succeeded in observing the famous "Schneeballenkirschen," of Schnœden. Moreover, the liquid of the common cysts often much resembles that of papillary cysts, without any particular character allowing us to distinguish one from the other. The absence of peduncle, the large insertion of the tumor in the pelvis, the bilateral character make us decide in favor of a glandular cyst. On the contrary, the dissemination of the tumor in the middle of the pelvic organs is a sign of very great probability in favor of a papillary cyst. The development of the two kinds of tumors is for the rest different. Although both complicated sometimes with dropsy, the author remarks that even with this an ovarian tumor, developing itself slowly and irregularly, is a sign in favor of a papillary cyst.

Concerning the malignity of ovarian tumors, the author, taking as a basis an experience of twenty years, affirms that they are much more serious than is generally supposed. There exists, he says, a great affinity between cysts and cancer. What renders

them less dangerous is that the intervention of an operation is made more rapidly. It must always be admitted, he adds, that they remain long stationary, and it is rare to see a repetition after an operation.

The author has made two hundred and sixty-four ovariectomies. Twenty times he had to deal with papillary cysts. This makes the proportion of six to seven per cent. in comparison with glandular cysts. Five times in these twenty cases the diagnosis has been made at the autopsy or at the moment of the laparotomy.

The true papillomata of the ovaries which are developed directly from the ovarian parenchyma, without giving place to the formation of a cyst, are very rare. They resemble papillary cysts in their etiology. The author has observed three cases, in one of which the papillomata were developed in great quantity in the Fallopian tube.—*Gazette de Gynécologie*.

TWO CASES OF PARTIAL SEPTUM OF THE VAGINA.—Reported in the *British Medical Journal*.—Mrs. M. B. was attended in her first confinement on June 3, 1882. The os was found to be dilated, and the head presenting. In the act of withdrawing the finger, the upper edge of a thin membranous septum was felt, which occupied the lower third of the vagina. This septum extended from the anterior to the posterior vaginal wall. Its upper edge was free, and as thin as a sheet of paper, but below it was considerably stouter and stronger, and, when grasped between the finger and thumb, appeared to be three or four millimeters thick. It formed a complete septum, dividing the vagina into two lateral halves, and extended from the ostium vaginæ to about one-third the length of the canal. As the head came down, the upper free membranous edge was torn through; but, as the lower and stronger part of the septum seemed to offer some impediment to the dilatation of the canal, it was snipped across with a pair of scissors, and the labor was completed in the usual manner. On March 1, 1886, Mrs. B. was confined with her second child. The remains of the septum could still be felt, but more distinctly on the upper than on the lower vaginal wall.—Mrs. J. W. was attended in her first confinement on March 18, 1885. This case was almost a counterpart of the former, but the septum perhaps did not extend quite so far. The same treatment was adopted, with the same result. No family connection could be traced between these two cases. The explanation of such an anomaly was simple enough. When the Müllerian ducts united to form the female genital canal, their fusion did not commence below and extend upwards, but, as Kölliker had shown, in the middle, and proceeded both upwards and downwards. In such cases the

fusion in the lower portion was from some cause arrested, while the development of the upper part proceeded normally.

URÆMIA WITH NEPHRITIS SCARLATINOSA.—(*W. Jacobowitzsch* in the *Trudi obtsch. Peterbg. detsk. Wratschei* 1887). The theories of Frerich do not suffice to explain, in all cases, the appearance of uræmia, especially if it appears in attacks with a normal, respectively-increased, daily quantity of urine. Jacobowitzsch relates the history of five cases, where children with nephritis scarlatinosa, with normal, and even augmented urinary secretion, suffered from attacks of uræmia and died. Post-mortem showed in all cases a great increase of the quantity of fluid in the lateral ventricles and œdema of the meninges and brain. This œdema the author shows to be the cause of death. Such an ensuing condition as this œdema of the brain, with normal meninges, the author explains through chemical changes of the blood, through the diseased alterations of the capillaries, and through the changes in the circulation of such patients. These three causes go more or less hand in hand. It is also shown that, in cases of uræmia with suppression of urine, the cause of death is not only to be found in chemical alterations of the blood, but, likewise, partly to be sought in œdema of the brain. The researches of Stepanow and Kuscow show that also in acute nephritis the walls of the vessels, but especially the capillaries, are diseased, and through such changes will œdema of the brain result.—*Centralblatt für Kinderheilkunde*.

THE MECHANISM OF THE THIRD STAGE OF LABOR.—Dr. Champneys, in dealing with "The Expulsion of the Placenta," in a paper before the Obstetrical Society of London, gives his own observations of seventy cases, carefully tabulated, as regards the manner of the expulsion of the placenta and the loss of blood in each case, together with the measures of the membranes and the presenting point of the placenta. The foetal surface presented in sixty-four, the maternal in two (in both of which the cord had probably been pulled on), the amniotic in four. Adding his results to those of Pinard and Ribemont, Dr. Champneys found that the foetal surface presented in one hundred and twenty-seven, the foetal edge in twenty-seven, the maternal surface in five. The presenting point was nearer the lower edge of the placenta in sixty-five, nearer the upper edge in one, midway in two, no note of the position in two. In the great majority there was complete absence of the fundal attachments. It was found that the presenting part varied in its position with the position of the placenta, the higher the placenta, the higher the presenting point and *vice versa*. The average loss of blood, before the expulsion of the placenta, was six ounces, in the membrane

or with the placenta six ounces, making an average of twelve ounces for each labor, not including *post partum* hæmorrhages. Hence a moderate loss of blood was a normal phenomenon in the third stage of labor. Dr. Champney's final conclusions were: (1) that some measurable hæmorrhage was a normal constituent of the phenomena of the third stage of labor; (2) the placenta presented in the great majority of cases by a point on the amniotic surface; (3) the presenting point was almost invariably near the lower edge of the placenta; (4) the position of the presenting point varied with the position of the placenta; (5) the "inversion" of the placenta was not due in the great majority of cases to traction on the cord, but was part of the natural mechanism. These observations, therefore, accorded in essentials with those of Schultze, though his diagrams were greatly exaggerated. These observations bore on the opinion previously expressed as to the causes and mode of separation of the placenta. Therefore, (1) it was probable that, in addition to reduction of the placental site, some escape of blood played a part in the ordinary mechanism of placental detachment; (2) the slight inversion of the placenta which did take place was probably due to this cause; (3) the effusion of blood was not, in ordinary cases, sufficient to form a large mass bulging into a large uterine cavity behind the placenta.

ON INTERVENTION IN FACE-PRESENTATIONS. By Dr. de Sayre.—Though this subject is not altogether new, it is one of extreme importance, as it was very commonly supposed that face-presentations were unnatural and required artificial aid early in labor. That this is not the case our more recent text-books show, and from large experience Dr. Sayre concludes (1) that in face-presentations early interference must be guarded against, and nature be allowed to bring labor to an end. (2) Owing to the cessation or insufficiency of uterine pains, or to an irregularity in or slowing of the foetal heart-sounds, or in severe hæmorrhage, convulsions, etc., it is necessary at times to interfere. (3) But even in these cases intervention is hardly warranted, unless the cervix is dilated or easily dilatable. (4) When the head will not engage in the brim, version is the best treatment. (5) If, however, the head is in the cavity, forceps can easily be applied. (6) Pelvic deformities do not modify in any way these conclusions, unless there is a marked disproportion between the size of the child and the pelvic canal.—*Archives de Tocologie.*

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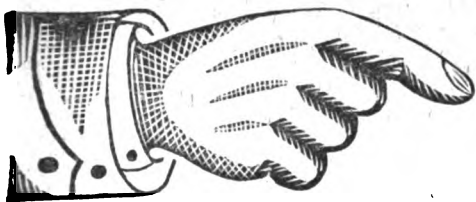
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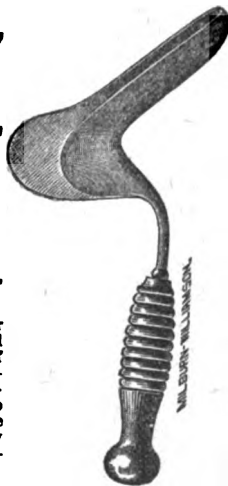
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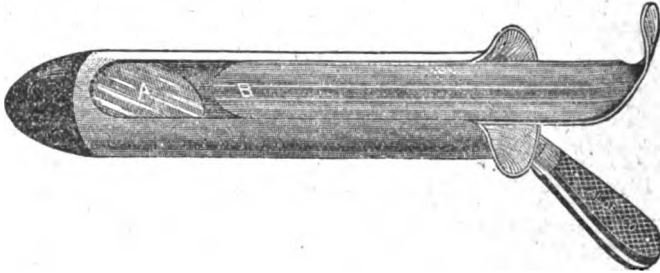
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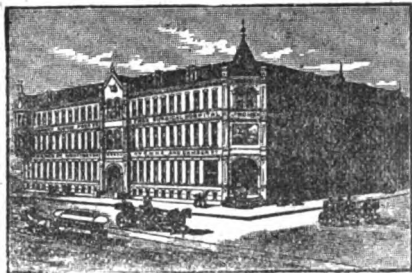
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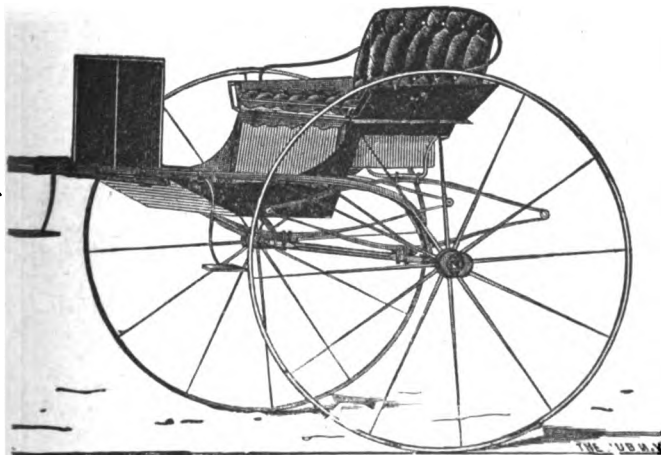
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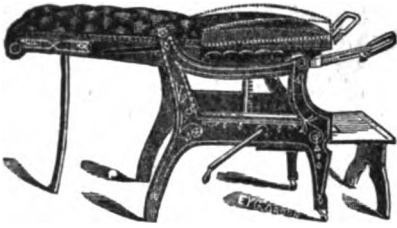


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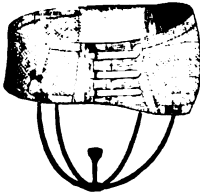
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CARNRICK'S SOLUBLE FOOD

Is the only infants' Food manufactured that perfectly nourishes the child without the addition of cow's milk. We do not except the so-called milk Foods, for they contain but a very small percentage of the solid constituents of cow's milk. Most of the credit given to prepared foods belong to cow's milk, which must be added to them or the child would starve.

THOMAS H. ROCH, M.D., Instructor in Diseases of Children, Medical Department of Harvard University, in the Boston Med. and Surgical Journal, Sept. 29, 1887, says: "Cow's milk is the universal menstruum of infant Foods all over the world, and is the actual food which the infant is getting: hence it is irrational and unfair to speak of and give the credit to the various artificial foods, when we really should speak of cow's milk, with its modification to a greater or less degree by certain adjuvants under the name of infant Foods, which all supply about the same variety of ingredients in common; such small amounts of these ingredients as to be of little benefit in nourishing the infant, and would not nourish it unless aided by cow's milk."

CARNRICK'S SOLUBLE FOOD

is positively the only Infants' Food manufactured to which the foregoing criticisms do not apply.

BEEF PEPTONOIDS.

(CONCENTRATED BEEF AND MILK WITH GLUTEN.)

Is the most concentrated and easily digested nutrient that has ever been introduced to the medical profession. Beef Peptonoids in the form of a powder is not a pure peptone, only one-fourth being digested. We are confident that you will find Beef Peptonoids in all cases where you desire a concentrated and easily digested food superior to any preparation in the market, or that can be prepared in the household.

The following are the opinions of most eminent authorities in the world:

PROF. ATFIELD says of Beef Peptonoids: "It is by far the most nutritious and concentrated Food I have ever met with."

PROF. STUTZER says: "When the formation of flesh and blood is to be promoted and vigor infused into a patient, Beef Peptonoids for this purpose stands first and foremost amongst all the preparations I have examined."

PROF. MACADAM, Edinburgh, says: It is by far the most concentrated, nutritive combination or essence of food which I have ever met with. It is thoroughly palatable and is most easily digested."

LIQUID PEPTONOIDS

Is presented in the form of an elegant Cordial, containing twenty per cent. of spirits. Its nutritive constituents are wholly digested. It will agree with patients who reject all other foods.

PEPTONIZED COD LIVER OIL AND MILK

IS SUPERIOR TO OTHER PREPARATIONS OF COD LIVER OIL.

Because the division of the oil globules is from twenty to one hundred times finer than any other preparation of Cod Liver Oil ever produced, and consequently brought nearer the condition required for assimilation.

It is predigested, and is, therefore, more easily retained by weak and enfeebled stomachs and eructations are less liable to follow.

Samples sent on application by

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OBSERVE THE NAME.
BEWARE OF IMITATIONS.

Liquid Beef Tonic.

ORIGINAL LABEL:
"Colden's Liebig's Liquid Extract of Beef
and Tonic Invigorator."

AN INVALUABLE AID IN THE TREATMENT OF ALL CASES OF DEBILITY.

ENDORSED BY SCORES OF PHYSICIANS.

ESSENTIALLY DIFFERENT FROM ALL OTHER BEEF TONICS.

COLDEN'S LIQUID BEEF TONIC consists of the Extract of Beef (by Baron Liebig's process), spirit rendered non-injurious to the most delicate stomach by extraction of Fusel Oil, soluble Citrate of Iron, Cinchona, Gentian, and simple aromatics. An official analysis of this preparation by the eminent chemist ARTHUR HILL HASSALL, M. D., F. R. S., and an endorsement by SIR BRASMUS WILSON, F. R. S., is printed on the label of each bottle.

In the treatment of all cases of Debility, Convalescence from severe illness, Anæmia, Malarial Fever, Chlorosis, Incipient Consumption, Lack of Nerve Tone, and of the Alcohol and Opium Habits, and all maladies requiring a Tonic Nutrient, it is superior to all other preparations.

It acts directly on the sentient gastric nerves, stimulating the follicles to secretion, and gives to weakened individuals that first prerequisite to improvement, an appetite. By the urgent request of several eminent members of the medical profession, I have added to each wineglassful of this preparation two grains of SOLUBLE CITRATE OF IRON, and which is designated on the label, WITH IRON, "No. 1;" while the same preparation, WITHOUT IRON, is designated on the label as "No. 2."

I will, upon application, send a sample bottle of COLDEN'S LIQUID BEEF TONIC to any physician in regular standing. Please ask your Dispensing Druggist (if he has not already a supply) to order it. In prescribing this preparation physicians should be particular to mention "COLDEN'S," viz: "EXT. CARNIS FL. COMP. (COLDEN)." It is put up in pint bottles and CAN BE HAD OF WHOLESALE AND RETAIL DRUGGISTS GENERALLY THROUGHOUT THE UNITED STATES.

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For sale by all Druggists at 25 cents a cake, or three cakes for 60 cents.

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BY FAR THE BEST TAR SOAP MADE. Has been on trial among physicians for very many years as a toilet soap and healing agent, and its superior virtues have been unanimously conceded in ALL CASES WHERE THE USE OF TAR IS INDICATED.

Unsolicited expressions of its excellence have been received from the Medical Faculty generally. None genuine unless stamped "A. A. Constantine's Persian Healing Pine Tar Soap." For sale by all Druggists.

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